S. Hrg. 101-173, Pt. 1

PHYSICIAN PAYMENT REFORMS

HEARINGS

BEFORE THE

SUBCOMMITTEE ON
MEDICARE AND LONG-TERM CARE

OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

MARCH 17 AND APRIL 20, 1989

(Part 1 of 2)

Printed for the use of the Committee on Finance

U.S. GOVERNMENT PRINTING OFFICE
20-595 WASHINGTON : 1989

For sale by the Superintendent of Documents, Congressional Sales Office
U.S. Government Printing Office, Washington, DC 20402

S361-47

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PHYSICIAN PAYMENT REFORMS

FRIDAY, MARCH 17, 1989

U.S. SENATE,
SUBCOMMITTEE ON MEDICARE AND LONG-TERM CARE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:05 a.m. in room SD-215, Dirksen Senate Office Building, Hon. John D. Rockefeller IV (chairman of the subcommittee) presiding.

Also present: Senators Baucus, Packwood, Chafee, and Durenberger.

[The press release announcing the hearing follows:]

[Press Release No. H-11, March 2, 1989]

FINANCE SUBCOMMITTEE TO HOLD HEARING ON PHYSICIAN PAYMENT REFORMS

WASHINGTON, DC—Senator John D. Rockefeller IV (D., West Virginia), Chairman of the Senate Finance Subcommittee on Medicare and Long-Term Care, announced today that the Subcommittee will hold a hearing on the "Physician Payment Review Commission's Report to Congress".

The hearing is scheduled for *Friday, March 17, 1989 at 10 a.m.* in Room SD-215 of the Dirksen Senate Office Building.

The purpose of the hearing is to allow the Commission to present its findings and recommendations to Congress relating to physician payment reform under the Medicare program, including its recommendations relating to the implementation of a fee schedule based on a resource-based relative value scale. This scale is a new concept in physician payments, developed to establish payment levels for services rendered by a doctor based on the amount of time and effort put into a particular service, as opposed to the current system of payments based on historical charge patterns.

Chairman Rockefeller said, "Physician payment reform under the Medicare program is a major area of concern to the Federal Government, the medical community, and beneficiaries. The Physician Payment Review Commission has devoted considerable time and effort to the analysis of this issue and the development of recommendations to Congress, and we look forward to hearing the Commission's report."

OPENING STATEMENT OF HON. JOHN D. ROCKEFELLER IV, A U.S. SENATOR FROM WEST VIRGINIA

Senator ROCKEFELLER. Good morning to you all.

This morning we are going to have our Subcommittee on Medicare and Long-Term Health Care begin the consideration of questions of whether and how to reform the way Medicare pays physicians. This is a beginning of a series of hearings that I think people have been waiting for a long time, some rather nervously, and all of us with a commitment to try to do what is fair and what is right.

We are going to have a lot more hearings on this. We are going to examine carefully and explore carefully ideas for improving Medicare's Physician Reimbursement System.

There doesn't seem to be much disagreement among people in the field that there is a need for some kind of major overhaul. The current Medicare methodology for physician reimbursement is barely comprehensible. It is confusing, in fact, not only for senior citizens but it is also very confusing for physicians themselves.

Now, Medicare spending for physician services has increased at an annual rate of 15 percent since 1980. A variety of strategies have been tried to contain these program costs, but for the most part these measures have been unsuccessful and inadequate.

This subcommittee heard testimony 2 weeks ago that, even without program expansions, Medicare spending for physician services is expected to triple over the next 10 years—triple, over the next 10 years. Therefore, unless major changes in the system are made, Congress will be forced year after year to tinker around the edges to achieve budget savings without really making any long-term difference.

What strikes me as a compelling reason for physician payment reform is the increasing financial burden on Medicare beneficiaries. Senior citizens are paying more and more out of pocket for health care. In 1988 the elderly spent just over 18 percent of their limited and, for the most part, fixed incomes on health care expenses, up from 12 percent only a few years before in 1977. So, unless we can reverse past trends, Medicare beneficiaries will continue to see their health care bills increase.

Today's hearing, as I indicated, is the first of a series of hearings. I myself am brand new to this subject, and I have a lot to learn. But I like that. This is a subject and an area which is important to me in terms of the people of my State, of our country. I frankly find it, intellectually, absolutely fascinating—imponderable and fascinating.

It is a glorious subject—inscrutable, but glorious. [Laughter.]

So, working with Senator Bentsen and his staff, Dave Durenberger, Bob Packwood, and others—obviously the Finance Committee staff and my own staff—I hope to do all that I can to ensure that we have a process in which everyone participates, and all points of view are heard and listened to.

I anticipate, to say the least, a rather healthy dialogue, a rather lively debate on the matter of physician payment reform. The Medicare Physician Payment System has essentially been unchanged since the Medicare program was first enacted. The type of structural changes that Dr. Lee and Dr. Hsiao will be testifying about on this day could have, probably would have, profound implications on the practice of medicine as a whole and the health care that our seniors receive.

Although today marks the beginning of congressional debate, I know that Dr. Lee and Dr. Hsiao have been immersed in the subject for years, and I commend you, gentlemen. You probably feel it is a less glorious subject than I do; but I really applaud both of you for your efforts, for your dedication. This is a moment that a lot of people have been waiting for. You will be looked to for expert advice and assistance as we explore these payment policies.

I am very pleased that the subcommittee has the opportunity to be the very first to hear first-hand your thoughts and ideas on how we might undertake this tremendous task before us.

As we know, the Medicare program was created as a major new commitment of the Federal Government to the Nation's senior citizens. In the early years, the Medicare program was viewed skeptically—that is interesting. It was viewed skeptically by many in the medical profession. I am pleased that the AMA and many other professional groups are very much involved and active participants in the current debate on improving this whole situation.

We encourage and we welcome the help of the entire physician community throughout this process. This is going to have to be a two-way street, and nobody is going to be entirely happy at the end of this process. It has to be two-way. It has to be honest. And we on the committee have to be the honest brokers working in the public interest.

The task before us is huge and complex, and by virtue of that fact alone we must proceed with caution and with care. If and when changes to the current system are developed, I believe we must be mindful of several key goals: access, quality care, acceptability, and fiscal soundness.

I am optimistic that we can come up with changes that are rational, well-understood, and, at least, widely accepted if not widely supported.

Again I welcome the witnesses this morning, and I look forward to what it is they have to say. I might suggest that we will start Dr. Hsiao with you.

I want to see if Senator Durenberger has a statement, and Senator Packwood, and then I would recommend that you both give your testimony. Then I will begin some questioning. But Senator Durenberger and Senator Packwood should feel free, on the points that the particular Senator is questioning on, to cross examine, so to speak. The Senators should feel free to come into the conversation; you two should feel free to disagree with each other or discuss openly with each other as we proceed.

So, Dr. Hsiao of Harvard, you are our first witness.

Senator PACKWOOD. Could I make just one quick statement?

Senator ROCKEFELLER. Yes, please.

OPENING STATEMENT OF HON. BOB PACKWOOD, A U.S. SENATOR FROM OREGON

Senator PACKWOOD. I don't want you to be discouraged by the fact that you are new to this. I knew a lot more about this subject when I was new to it than I know now. [Laughter.]

It may be mentally stimulating; I am not sure "intellectually invigorating" is what I would say. But what I am frightened of is this:

I see us moving toward a sort of homogenized medical system, and I am not sure that is good for the country. We are doing it now with the MAAC's, and we are gradually moving toward a system where we are going to pay 55-year-old experts the same as we are going to pay 30-year-old novices for doing the same procedure, even though one may have 25 years experience and the other is barely out of residency. I am not sure that is a good system.

I don't think the bulk of the public knows we have price controls on doctors. We do. Short of putting price controls on doctors, or requiring mandatory assignment, I don't know how we achieve the dual goals of attempting to restrain Federal Medicare payments and restrain increases on payments by beneficiaries.

If we don't put price caps on doctors, and if we say henceforth Medicare is going to pay 80 percent of what it paid instead of 100 percent, and we let the physicians charge what they want, they will increase the cost to the beneficiaries. If we think that is horrible and attempt to put a limitation on what they can charge beneficiaries, then we squeeze more and more doctors into the same square or round hole, to no benefit to the country.

I don't have an answer to this. Clearly, the way we deliver health services in this country, is not very popular with the public. We spend an incredible amount of money in terms of our per capita income, more per capita than any other country in the world, and have seemingly failed the mark.

So, 10 years ago I knew the answer. Now, I don't. And I hope that the doctors who are here today can help lead us out of this wilderness.

OPENING STATEMENT OF HON. DAVID DURENBERGER, A U.S. SENATOR FROM MINNESOTA

Senator **Durenberger**. Mr. Chairman, 10 years ago I came to this committee and learned my health policy from my colleague on my left, who then, along with my colleague who was on my immediate left, but is over doing Eastern Airlines or something right now, were the leaders in this country on health care delivery and on the reform of health care financing.

When I first took a major role in this committee—I guess all of us were "the" deciding vote against hospital cost containment. I think the message sent was that, "We don't want homogeneity; we don't want this run like your local gas or electric utility," but from then on it has been pioneering.

I think we are starting that today, with the pioneer to our right—maybe even philosophic right, I don't know; he is from West Virginia. [Laughter.]

I think it is, for me, as both of you gentlemen have said, a rather exciting moment. I served 6 years as the Chair of the Health Subcommittee of this committee during which I abandoned my pipe, as Herman Talmadge who preceded me probably abandoned his cigar. A lot of changes have happened in this country, it is just absolutely incredible.

I am really very pleased that I have had the opportunity, during that 6 years, to create so much legislative activity in the health field that it now takes two subcommittees to do the work.

I am particularly pleased, though, that my colleague from West Virginia is the Chair of the major of these two subcommittees, Long-Term Care and Medicare.

During our "creative period," as I call it, which includes the early eighties and in 1983 in particular, we made the very first revolutionary change in U.S. health care delivery by changing the way third-party payors reimburse hospitals. Nobody noticed it at the time—we hung it on the Social Security reform. But people have forgotten about Social Security reform because it is generating so much money. They are now worrying about the fact that in 10 years Medicare is going to cost more than Social Security.

The introduction of PPS, the Prospective Payment System, to hospitals and Medicare brought incredible efficiency to our system. It substantially reduced the use, growth, and costs of hospital care. But without comparable change in physician and outpatient payment, we continue to move toward health financing bankruptcy.

The growth in costs, charges, and volumes of services in this area must be stopped. It is not good for Americans, it is not healthy for Americans. Today we will begin that process.

In 1986 we created the Physician Payment Review Commission. Today we received their proposal for a new physician payment system. Their work has been diligent, their proposals intelligent.

I compliment Dr. Phil Lee, and Paul Ginsberg, and all members of the Commission. I compliment Dr. Hsiao for his work and that of his colleague. I compliment our staff. I take it this is somebody on the majority side, because in two pages they have more than adequately summarized all of the work of the Commission and have done it in an incredibly effective way. [Laughter.]

So, whoever did it, I compliment you.

I guess I would like to say I endorse the recommendations of the Commission: (1) To pass appropriate legislation by October of this year, (2) to adopt the resource base relative value scale, to see all of that go into effect by April 1 of next year, (3) to have it go into full effect by April 1 of 1992, (4) to correct the specialty inequities that exist in this country that discourage a lot of good practice of medicine. I am going to comment on this briefly—to correct geographic disparity I hope that you can prove that you are going to do it, and to do all of that with some kind of expenditure caps and some kind of limitations on balance-billing. I guess that will be one of our major challenges here, within the context of this full committee, to decide the appropriateness of expenditure caps and the issue of balance-billing.

There are two other recommendations I would like to add: In particular, one is to examine closely HMO and CMP reimbursement policies—incredibly important.

If in fact we are all going to end up buying our health care via health plans, we must do something about the failed experiments out there in the last 3 years in competitive medical plans.

Then, finally, we must define our direction for proposed effectiveness, and quality research, something this committee has been involved in for a long time.

The chairman said this is all about equity access and quality. He is absolutely right. All of the recommendations of this committee, I believe, are aimed in the direction of ensuring equity, access, and quality for all the elderly and the disabled in this country.

Today, the elderly in my State, and I am sure in West Virginia as well, are substantially discriminated against by the Medicare system. This is because they pay much more out of their pockets for their health care due to Medicare paying so much less to the doctors and the physicians in my State.

In the rural areas of my State—were part of a study somebody did here; maybe it was the Commission who did it. They had 219 sites studied on the relative level of reimbursement on a series of selected procedures. Southwestern Minnesota and northern Minnesota ranked 217 and 216 out of 219. That is why I am going to put in the record one article out of a thousand that came from my home State, about "Small Towns Seeking Cure for Doctor Shortage."

[The article appears in the appendix.]

The average age of physicians in rural Minnesota is 57—57. The Twin Cities—the big urban area in our State—ranks second from the bottom,in comparison with all other urban areas of our State, in terms of the reimbursement to its doctors, to its physicians.

At this point, nobody wants to come and practice in Minnesota. This is already happening, physicians are already quitting and going to other places which are more financially lucrative. And the good people don't want to stay there. Besides being unhealthy for the reputation of the State. It is particularly unhealthy for its population as well.

We all pay the same amount into the Medicare system; we all ought to get out equal service from that. It is unfair that if you happen to go and live in Miami, and practice in Miami, you can get paid two, three, four times as much for the same procedure on the same person than you do in Minneapolis. That has got to stop, and I will stay on this committee long enough to see that that changes.

I congratulate the members of this Commission for their willingness, to cooperate in this matter and thank all of the people that supported them. The specialty associations, the AMA, a lot of other organizations and individuals have supported this effort, as I understand it. Not everybody agrees with all of it; but I think that it was a tribute to the hospitals of this country that they bought into PPS. I expect that we will pay tribute to the physicians in this country for their accepting a modified form of reimbursement. Hopefully it will be adopted by all third-party payors.

Thank you, Mr. Chairman.

Senator **Rockefeller**. Thank you, Senator Durenberger.

I want to say very clearly, as I head into this chairmanship, that I am awfully glad you and I will be working closely together, because I don't know of anybody who knows more about health care and its intricacies, and shares the same kinds of problems that we do in West Virginia in Minnesota than does Dave Durenberger. So I feel very good about that.

Those who will come before this committee will find that this is not a partisan committee; we are a bipartisan committee, and they will find, also, that we are fair.

They will find something else which is interesting: This committee used to be known as an "oil and gas committee." That is not true anymore. If it can be characterized in any way, any particular characteristic, I would say that it is a "rural committee," dealing with major financial and health care problems.

Having said that, Dr. Hsiao, we look forward to hearing you. There is not a 5-minute clock on this morning; you and Dr. Lee are our only witnesses, the two of you. So, let us make this an interesting dialogue.

Please.

STATEMENT OF WILLIAM C. HSIAO, PH.D., PROFESSOR OF ECONOMICS AND HEALTH POLICY, SCHOOL OF PUBLIC HEALTH, HARVARD UNIVERSITY, BOSTON, MA, ACCOMPANIED BY DR. PETER BRAUN, INTERNIST, PRIVATE PRACTICE AND LECTURER IN HEALTH POLICY AND MANAGEMENT, HARVARD SCHOOL OF PUBLIC HEALTH, CO-PRINCIPAL INVESTIGATOR, RBRVS

Dr. Hsiao. Mr. Chairman and members of the committee, first of all let me say I am not a real doctor, so I brought a real doctor with me, Peter Braun, M.D. who is sitting to the left of me. He is a senior physician who worked closely with me on the development of RBRVS. We are pleased to appear before you this morning as you open hearing on the reform for physician payments.

My testimony will cover five major points:

The first is why the Government decided to fund this Resource-Based Relative Value Study. Since you have such a large deficit, I am sure you would want to make sure the money was spent wisely.

Second, what is this RBRVS, and how was the study done?

Third, what are our major findings?

Fourth, what are the criticisms of our study, and how do we plan to address them?

Last, what are some of our major recommendations and conclusions?

Let me turn to my first point, the reasons for this study.

There is a widespread agreement among physicians, policymakers, researchers, and the public that physicians' fees are unfair and inequitable because we they have been distorted by three major factors: The first is the insurance coverage, the second is the administrative rules that set the payment rates—namely, the UCR method—and the third, patients' inability to make rational choices when they face life-threatening situations.

Distorted fees offer perverse economic incentives to physicians and, hence, may affect their clinical decisions when they decide on tests and treatment choices. These distortions in the incentives could contribute to the rapid inflation of health care costs and promote the performance unnecessary tests and procedures. So, in other words, an inappropriate incentive structure can affect cost, quality, and possibly access.

Any serious attempt to control the health care cost must set a level economic playing field for doctors, because their clinical decisions largely determine the expenditure of 80 percent of our health dollars. Although physicians only receive 20 percent, they are the key decisionmakers that decide how 80 percent of the health dollar is spent.

You recognized the need for reforming the physician payment system when, in 1985, Congress mandated a study to develop a resource-based relative value scale.

Now let me turn to what we have done.

Because most physicians are paid on a fee-for-service basis, we aim to develop a relative value based on the resource cost required for each service. And that is a formidable task, because there are 7,000 services classified and coded for physicians' work.

We began by investigating first what constitutes resource costs. Then we selected appropriate methods to measure them. And then, lastly, we tested whether our results have any scientific validity.

The development of the RBRVS is a complex task. We also share your philosophy and view that all of the important parties should be consulted and should participate in such a complex study.

Therefore, we subcontracted the American Medical Association and called on their support and assistance, also asking for the cooperation of more than 30 specialty societies.

We appointed physicians to serve on our Technical Consultant Groups. With the AMA and the 30 specialty societies, we appointed 100 physician advisors to the study. These advisors assisted us in defining what constituted the resource cost for their services, commented and advised us on our methods and data, and then, finally, evaluated the reasonableness of our results.

So I would like to acknowledge publicly that we are very much indebted to the whole physician community and particularly to our 100 physician advisors.

We define "resource input" as being made up of three factors: The first is the work performed by the physician for a particular service or procedure, so it is a physician's work input; the second is the overhead cost, which includes the professional liability insurance premium; and then, last, the cost of education for a physician to become a qualified specialist.

The total work involved in physician services encompasses five dimensions. I would like to emphasize that. There are five dimensions, not just one.

First is the time spent before, during, and after the service; second, equally important, is the mental effort and judgment required; third, the technical skill; fourth, physical effort; and then finally, the stress felt, or what I call "the sweat on the brow," when a physician performs a difficult task.

I would like to emphasize that all of the important data to construct the Resource-Based Relative Value came from practicing physicians. We did not generate the data internally; we obtained this data through surveys.

Furthermore, because of both the unprecedented and sensitive nature of the study, we had our methods, data, and results reviewed by 29 nationally recognized experts in economics, medicine, statistics, psychology, and health policy research before they were published and released.

Two reviewers summarized their findings and those of other experts this way: "The RBRVS researchers obtained generally accurate, reliable, and consistent estimates of relative work, and also successfully linked them into a common scale," and Dr. Phil Lee in a few moments will share the Commission's conclusions about the credibility and soundness of our work.

Now let me turn to what did we found:

Our study led to five major findings. We found that resource costs for physician services can be defined by a systematic and rational approach.

There is a high degree of agreement among physicians on the estimation of work for the services performed within their specialty.

A third finding: We found that the work input for physician services can be measured—so besides that we can define resource costs, they can be measured with the appropriate method. And the work values can be successfully put on a common scale across all specialties.

The fourth major finding is that we did comparative and statistical analysis and found these estimations of work are reproducible and consistent. Therefore, we concluded they are reliable and valid. Furthermore, these results were reviewed by our physician advisor panels, and in most cases they found our results have face validity.

There is a major fifth finding. We divided the work performed by physicians into dimensions I mentioned earlier: time, mental effort and judgment, technical skill and physical effort, and stress. We found all of those factors are important, and they are included in the relative value.

Time alone is not adequate to explain work. As a matter of fact, in the relative value for surgical services, surgeons rated technical skill as having greater weight than time spent; mental effort and judgment as having equal weight as time spent.

So, I would like to emphasize, then, for surgical procedures, time is only one among four factors for the relative values; it is not the only factor.

In comparing surgical procedures and office visits, we found that the intensity—"intensity" defined as how much work per hour—the intensity for surgery can be seven to tenfold times the intensity for hospital visits and office visits. In other words, in this relative value, the surgical procedures require much more intensity, not only time. So, if a surgeon can keep him or herself busy full-time doing surgical procedures, under the RBRVS she will be compensated much more because she will be performing much more intensive work.

Then, what is the potential impact if this RBRVS is adopted for payment policy?

We first compared the current charges with the resource-based relative value, and we found the current charges do not reflect the required resource costs. For office and hospital visits and consultations, the Medicare program is currently paying between $25 to $45 for every 100 units of resource cost. Meanwhile, for most surgical procedures and tests, Medicare is paying $100 to $160 for 100 units of resource cost. In other words, procedures and tests are compensated much more generously than those primary-care services.

Therefore, these results allow us to conclude that the economic playing field for physicians is not level. The more generous payments for surgery and tests could induce a greater and inappropriate volume of these services.

The second major impact I would like to share with you is that, if congress replaces the current payment system with the RBRVS-based fee schedule, there could be some significant increases in fees for office, hospital, nursing home visits and consultations, while surgical fees could be reduced 10 to 35 percent.

To evaluate this potential impact, we simulated a possible effect under a budget-neutral assumption, and the results are shown in figure 3, which is attached to my written testimony.

You will see that most specialties will not be affected greatly; yet, for six specialties, revenues from Medicare could increase or decrease up to 30 percent. This is quite similar to the findings of PPRC.

Now let me turn to the limitations and criticisms.

While we find, on the whole, this study has credibility and is sound, we know there are limitations and shortcomings to the RBRVS. Furthermore, since the release of our 2,000-page final report to the Health Care Financing Administration, we have received many criticisms of this study.

Let me assure you that we paid close attention to these criticisms, and we gave them careful consideration. We found some criticisms are well-founded, while others are not. I would like to give you a summary of the important criticisms and tell you how we plan to address them.

First of all, we acknowledge there are limitations to the RBRVS, and one was pointed out by Senator Packwood. In the RBRVS we did not measure the differences in the competency of the physicians. As Senator Packwood pointed out, a physician who is 30 years old and somebody who is 50 years old with 20 years more experience, the RBRVS does not take into account the level of competency and experience of these two physicians.

We found out that the current level of knowledge cannot differentiate systematically the quality and competency of physicians' work, because there are 500,000 practicing physicians in the United States. Nevertheless, if the RBRVS is adopted, you could incorporate, Senator Packwood, when a quality index is developed that can accurately measure the physicians' competency and quality of services.

Now let me turn quickly to the criticisms.

We found that, yes, there are serious shortcomings as to how we treated the overhead costs. We also did not have the most up-to-date information on overhead costs to incorporate in the RBRVS.

Furthermore, our measurement of the services and work performed before and after the service, are not that precise. And in addition, some of our results did not receive adequate validation, because of the time pressure and also the volume of material that we had sent out to competent people to review our material. They did not have adequate time to validate and review the material.

I have listed these criticisms in my oral testimony, and they are also further elaborated on in my written statement. Let me just point out some highlights of how these shortcomings and criticisms will be addressed:

The PPRC already is working to improve the treatment of overhead cost, and Drs. Lee and Ginsberg in a few minutes will share with you how they plan to modify it.

We have also submitted to the Health Care Financing Administration a proposal for supplemental funding to conduct further investigation and address these shortcomings. We have developed definite plans and workable approaches to correct and improve the results we have produced to date. As I mentioned, more detail of those study plans is given in my written statement.

Now let me mention five specialties: psychiatry, dermatology, cardiovascular and thoracic surgery, ophthalmology, and pathology. These five specialties have pointed out to us that we have not adequately considered some important and special characteristics of their work that may be unique to their specialty. Also, there are coding problems with these specialties.

Consequently, we have agreed to restudy and resurvey psychiatry and dermatology. We have also met and held extensive discussions with the other three specialties. We are confident that mutually satisfactory agreements can be reached for us to restudy and resurvey those three specialties—thoracic surgery, ophthalmology, and pathology—if those three specialties decided that is the best course of action to address their concerns.

Now, our study also had been criticized for many other shortcomings, and I would like to mention a couple of them. We were criticized for employing magnitude estimation methods to obtain the estimation of physicians' work, and also for taking geometric means to calculate the relative values. These terms are quite technical and esoteric, so I won't bore you by explaining what they are.

But let me say that we took these criticisms seriously and have conducted further analysis. Up to this point we found these criticisms, which were often made by persons unfamiliar with the technical subject matter, to be without foundation.

So in summary, then, we found some criticisms are well-founded, and some of them are not well-founded. For those that are well-founded, we already have efforts underway to restudy and to improve and refine the work we did previously.

Now let me turn to the last part of my testimony that is related to our recommendations and conclusions.

After the internal and external critical review of our study, we concluded that the results of the RBRVS are generally sound and credible. Therefore, the resource-based relative value method is a feasible alternative for paying physicians' services. We believe the RBRVS offers a rational and systematic method to establish payment rates.

Yes, the RBRVS can be improved and refined, and this effort is already underway. We are confident that we can improve the relative values and that it can be completed for full implementation, if you desire, by the end of next year.

Our second recommendation relates to the coding system. There is a great deal of ambiguity in the current coding system. Because of these ambiguities, physicians and carriers use these codes differently. Without a national uniform coding system, we cannot assess accurately what services are being performed. In other words, we don't really know what we are paying for. We also cannot assess accurately how much the volume of services has changed.

We cannot prevent the unbundling of services or deter "code-creep" for larger reimbursements. These problems of the current coding make it difficult, also, for us to estimate accurately the resource costs required for these ambiguous codes. Therefore, we recommend the Congress mandate the establishment of a national and uniform coding system that corrects the ambiguities in the current codes as well as the uniform application and use of these codes by physicians and carriers.

Our third recommendation is related to the desirable transition period to implement a RBRVS system. I pointed out that a payment reform based on the RBRVS could have a quite severe financial impact on physicians in several specialties. We would recommend a gradual transition from the current payment method to an RBRVS-based fee schedule over a 4-year period, to allow for orderly and gradual adjustments in physician practices, and to avoid sharp distortions.

Our fourth recommendation relates to the implementation of this RBRVS-based fee schedule. We recommend that evaluation should be an integral part of implementation. At this time we do not have adequate information to predict accurately how physicians and patients would react to changes in the relative price for physicians' services. There could be positive effects on access, quality, and cost; but there also might be negative effects.

We strongly urge you to require the establishment of several sites where the effects of a new system could be carefully evaluated. I will be happy to supply any details if the committee wishes me to do so.

The information collected from these evaluation sites could guide you in making mid-course adjustments in the implementation of the payment reform.

In summary, then, the current physician payment system is widely criticized for retaining historically distorted fees. Distorted fees, in turn, present perverse incentives to doctors. These distorted fees could lead to provision of inappropriate services and could promote more rapid inflation of health care costs. In other words, perverse incentives in our current system affect both costs and quality.

We believe that the RBRVS offers a feasible systematic and rational approach to establish a better payment system. By removing the perverse incentives, the RBRVS could enhance cost-effective medical care and also ameliorate the physician shortages in some primary-care specialties.

Thank you very much.

Senator **Rockefeller**. Thank you, Dr. Hsiao.

[Dr. Hsiao's prepared statement appears in the appendix.]

Senator **Rockefeller**. Dr. Lee, as I call on you, I did not put on the 5-minute system. On the other hand, I would like you to be as efficient as you possibly can.

STATEMENT OF PHILIP R. LEE, M.D., CHAIRMAN, PHYSICIAN PAYMENT REVIEW COMMISSION, AND DIRECTOR, INSTITUTE FOR HEALTH POLICY STUDIES, SCHOOL OF MEDICINE, UNIVERSITY OF SAN FRANCISCO, SAN FRANCISCO, CA, ACCOMPANIED BY DR. PAUL GINSBURG, EXECUTIVE DIRECTOR, PHYSICIAN PAYMENT REVIEW

Dr. **Lee**. You have a two-page summary which we think is an excellent summary of our 16-page testimony, which in turn is a summary of a 300-page report. We want to commend your staff for an outstanding job, and I will try to be brief in reviewing the recommendations of the Commission.

The comments that each of you made reflected the dilemmas and issues that were facing the Commission during the last 2½ years, as it attempted to respond to the Congress's request both to make recommendations with respect to payment reform and to make recommendations to slow the rate of increase in expenditures in the Medicare program.

The Commission completed its deliberations for this year's report just a week ago, and I want to now summarize those recommendations.

Basically, we are recommending that Congress adopt the Medicare fee schedule based primarily on resource costs. We are recommending a limit on beneficiary financial liability, particularly through limits on balance billing; we are recommending controls on expenditures through expenditure targets; and we are recommending policies to deal with the increased volume of services through increased research on effectiveness of medical services, the development of practice guidelines, and more efficient and effective utilization review.

Let me briefly discuss the proposed Medicare fee schedule:

First and foremost, it replaces the customary prevailing and reasonable payment policy that has been in effect since the initiation of the Medicare program in 1965.

The elements of a cost-based fee schedule include a relative value scale—and Dr. Hsiao has discussed this in detail; a dollar conversion factor which would convert the RVS to a dollar payment or a fee schedule; and, a geographic multiplier that would take account of practice cost differences between different geographic areas.

Dr. Hsiao has discussed already the relative physicians work, which is one of the two major elements in a relative value scale. The second is practice costs.

The Commission is working to modify one area in close cooperation with Dr. Hsiao, and that is to incorporate time in evaluation and management visits—office visits, hospital visits—because the current coding system does not accurately reflect the work that is involved in those visits.

We also have developed, with a consensus group of surgeons and carriers, a policy with respect to global surgical services, and we think that will be a significant improvement over current policy.

We are also suggesting that Congress postpone legislation which would mandate the grouping of codes. We think the proposals we are making are a more appropriate response to the problem that was identified, and we would suggest that that decision be postponed.

With respect to practice costs, the Commission is using more updated data than was used originally by Dr. Hsiao last year when he first developed the practice-cost component of the RVS. We are also recommending that practice costs be an additive part of the resource based RVS rather than a multiplication factor as originally developed by Dr. Hsiao and his colleagues. Although initially we were using practice costs by specialty, we hope to supersede that by estimates of practice costs by category of service when the data becomes available.

Finally, in practice costs, we would recommend strongly that malpractice or professional liability premiums be separated from other practice costs and dealt with separately in the practice-cost component of the RVS.

The RVS has to be updated annually, and we think that the process that the Commission has used this year may be one that the Congress would find appropriate. We believe that the medical profession must be substantially involved in that process, as they have been with Dr. Hsiao in the development of the RVS, and as they have been involved with the Commission during the past 2½ years.

The conversion factor, the dollar conversion factor, we believe should be revenue-neutral at the initiation of the process. It does relate to expenditure targets, and I will say little bit more about that when I talk about expenditure targets.

The geographic multiplier the Commission recommends relate to overhead only. That is practice costs only, not the physician net income component.

We are recommending that specialty differentials be eliminated in the new Medicare fee schedules, because we do not believe that they will be necessary.

On assignment and balance-billing, one of the more important areas, the Commission did not favor mandatory assignment. The Commission did recommend a limit on balance billing on unassigned claims, by it did not recommend a specific limit. In the past, Congress has established limits of 115 to 125 percent on balanced billing. The radiology fee schedule established by Congress mandated that balance billing decline from 125 percent to 115 percent.

We do recommend mandatory balance billing for qualified Medicare beneficiaries identified in the catastrophic legislation last year. Congress did not specify specifically in the legislation that assignment be mandatory for those individuals who we interpret as Medicaid recipients—and that balance billing be eliminated for the QMB's. That, we think, needs to be specified.

We recommend continuation of the participating provider program, the so-called PAR program, with the 5 percent higher payment for the fees for those participating physicians.

With respect to the transition, we are proposing that a transition fee schedule go into effect in April of 1990, assuming legislation is enacted by October 1989. The transition fee schedule will change the current prevailing charges in the direction of the resource-based relative value scale fee schedule that we would recommend go into effect in 1992. So, you would have a 2-year transition before you reach the new fee schedule.

During this transition, payments for evaluation and management services would increase, payments for many procedures would decrease, consistent with the ultimate policies that would be adopted with a resource-based relative value scale. We recommend that the Medicare fee schedule go into effect in April 1992.

It is very important that there be an adequate system for monitoring access. We have four tables attached to the testimony that show briefly the changes for selected services, the impact on certain specialties, the geographic impact, and the impact on out-of-pocket expenditures and balanced bills. It is of critical importance that adequate monitoring be in place on access to care and beneficiary financial liability, so that, if fine-tuning of policy is necessary, Congress and the Health Care Financing Administration will have the information to do that.

To slow expenditure increases, we are recommending three major initiatives. One, expenditure targets. We are recommending a national expenditure target per enrollee To calculate the annual rate of increase in expenditures it would be necessary to include practice costs, the increased number of beneficiaries, and the projected increase in volume of services. The practice costs would be similar to the MEI but, rather than simply be a projection, it should be based on actual costs so that the practice cost figures would be more accurate. Beneficiary increases have been about 2 percent a year, and the increase in the volume of services in recent years has been about 7 percent a year. The expenditure target would include those three components.

The annual update, once the target was set initially, would be adjusted if expenditures exceeded the target. The percentage increase in the fees would be reduced in the following year to recover the expenditures in excess of the target. In other words, we expect that fees will go up each year because of increased practice costs related to inflation. But if the target is exceeded, the rate of increase would be reduced by that proportionate amount.

By the same token, if the target was achieved, the full payment would be made on the fees. If expenditures were below the target—in other words, if expenditures did not reach the target—then there could be a proportionate percentage increase in the payments to physicians.

A second area that we think needs major support from the Congress is effectiveness research and practice guidelines. There have been a number of steps in this direction.

Dr. Roper last year really initiated a major effort with HCFA; that needs to be very substantially expanded. The primary purpose of the Medicare program is to provide access to quality care, and one of the best ways to find out what is appropriate care, what is quality of care, is to expand the research area. With expanded research there also needs to be developed, through consensus, practice guidelines that can be used nationally by hospital staffs, by carriers, by PROs, by the medical profession.

The third area to improve is the present utilization review practices by carriers and PRO's, get them working more effectively together and get the medical profession more involved with both the carriers and the PRO's.

Another major area we addressed in the testimony is the infrastructure for payment reform. We applaud HCFA's efforts to introduce a unique physician identifier, to incorporate diagnostic information on claim forms, and to develop a common working file including data from Parts A and B, but without adequate funding for these and related medical review activities serious problems can arise.

We would suggest that the Congress require providers to submit all claims. We think that would provide a more accurate record. It would also expedite the claims processing. We also think that there should be acceleration of the trend towards electronic claims submission.

More important, adequate funding for the Health Care Financing Administration, the carriers, and the PRO's, for their medical review activities is essential. Those dollars save many dollars, and to reduce the funding for those, as has been proposed by the Administration, we don't think makes sense.

Finally, we make some recommendations with respect to capitation. In 1986, Congress enacted provisions to prohibit HMO's and CMP's from using financial inducements to reduce or limit Medicare services. And this was to go into effect in 1990.

We would suggest that a modification of those prohibitions be made to limit the total risk assumed by physicians through some sort of stop-loss, that group incentives rather than individual incentives be used, and that the physicians be informed and beneficiaries be informed appropriately of information on the compensation plans by the HMO's and the CMP's.

In summary, Mr. Chairman, we believe that the Commission has made a comprehensive set of recommendations to deal with the very complex and perplexing issues which we all face with respect to the Medicare program. As you pointed out, assuring access, providing quality care having care acceptable, having equity, and also having the program be fiscally sound are important goals. We think the Commission's recommendations, although perhaps not popular with everyone, will in fact achieve those objectives in the long view.

Thank you.

[Dr. Lee's prepared statement appears in the appendix.]

Senator ROCKEFELLER. Thank you, Dr. Lee.

Dr. Ginsburg and Dr. Braun, we also want to welcome you here. I failed to do that at the beginning.

I would like to start questioning with Senator Durenberger, and point out to Senator Packwood that as Senator Durenberger is making questions and responses are being made, on that point if you want to interrupt or follow up on questioning—and, Dr. Hsiao and Dr. Lee, and Dr. Ginsburg, Dr. Braun, if you want to get into it—feel free to do so, so we will get a discussion going. And we will continue until 12:00.

Senator DURENBERGER. Thank you, Mr. Chairman. I will try to limit myself, then, to 5 minutes and then come back, as Bob and you will have questions I am sure you will want to ask.

In trying to make up my own mind, gentlemen, about what to endorse and what not to endorse, one of the most difficult issues for me is the fact that this is another basically regulatory approach to reimbursing health care providers. And to the extent that it attempts to provide a payment that pays everybody about the same for equal service provision, it would appear to present us with problems. Those of us who believe in competition in the marketplace, and consumer choice, and all of those wonderful things that begin with "c" that seem to be raising costs of health care in America.

Just to get a little reaction from all of you, let me quote a couple of items from one of the more well-known people who disagrees with a regulatory system, our friend and your colleague Dick

Egdahl. I think it is from the material that he sent to HCFA as they were analyzing some of this work.

"The RBRVS approach is fundamentally a massive regulatory approach to fee schedules and ignores the rapidly emerging competitive market. Over the past several years, corporations and insurance companies have carried out extensive negotiations with physicians, and these actions are intensifying"—that is why their rates are so low for physicians in the Twin Cities.

"HMO's are cutting deals with hospitals and their related physicians for global payments for services, such as cardiac surgery or cancer chemotherapy, leading to internal negotiations between the hospitals and the physicians—often with considerable decrements in the fees charged."

He then goes on to talk about other arrangements that we are aware of in the country.

With regard to society's access to health care, he says, "Even if one were to accept the highly regulatory process for achieving that objective, the RBRVS should not be adopted if the key goals of the program are to achieve access"—as the chairman said—"to qualified physicians at the lowest possible cost."

He then cites the RBRVS experience in Massachusetts and goes on to say, "With the rapidly changing patterns of physician manpower, the early retirement from active practice of specialists with very high malpractice risks"—early retirement that I talked about earlier, the average age being 57, and so forth, people not coming into medical practice in some areas—"it would be hazardous to launch a non-market regulatory approach to fees at this time.

"The RBRVS-derived fee would have to be increased, in many instances, in order to get access to care. And a negotiated fee lower than might be derived by formula would succeed in gaining access in areas with a surplus of certain kinds of physicians."

And I ask this also, as you understand, in the context that once Medicare goes to this system, probably everybody is going to be going to it. So we are not just talking about the elderly and the disabled; we are potentially talking about the whole country moving in this direction.

Dr. Hsiao. Senator Durenberger, let me first say that I think Dr. Egdahl has misunderstood the economic principles behind market competition. Market for physician services just does not work very well.

Without belaboring this point, just let me refer to the godfather of the pro-competition for health care, namely Alan Enthoven of Stanford University. Even Dr. Enthoven has acknowleged publicly that competition doesn't seem to work in the health sector; therefore, he now calls for "managed competition." "Managed" means correct the inappropriate incentives, and use regulation to promote competition so it can work at some places.

Dr. Egdahl failed to explain that if you want to make competition work, you have to make the patients pay the fees directly out-of-pocket. We have widespread insurance coverage for surgical procedures. People don't pay when they go for medical services. That is one major reason why competition is not working in health services. If Dr. Egdahl wants competition to work, he has to eliminate the current health insurance.

Second, the consumer has to be able to make rational choices to create a competitive marketplace. If somebody is bleeding, if somebody's heart has begun to beat irregularly, I don't think that consumer is in a frame of mind to do competitive price-shopping.

So I think tc embrace that competitive ideology without a critical examination puts doubt in my mind at least.

Now, you asked about access. Let me just say that a study conducted the American College of Surgeons in 1974 found there was a surplus of surgeons. As a result, today the average surgeon spends less than 20 percent of his time doing surgery; other times the typical surgeon is doing other medical services. So I don't think that lower surgical fees, would generate a serious access problem, because we have a surplus of surgeons who are clamoring to have more surgical work. I would worry about the opposite—namely, because we have an oversupply of surgeons, we have some inappropriate and unnecessary procedures being performed.

Senator **Rockefeller**. Dr. Lee?

Dr. **Lee**. As a non-economist, I would share Bill's comments about the imperfect market. Medical care is not a perfect market, and he has pointed out the two fundamental problems: One is, most people do have insurance; and, second, patients cannot be adequately informed about quality or about price, and those make this not a truly competitive system.

HMO's, by contrast, if they were developed on a large scale, as proposed by Alan Enthoven, where you would have what he has called "managed competition," with competing plans, competing HMO's, then you could truly have competition. You could inform the purchasers of care of their choice. There would also have to be adequate oversight by government to assure the quality of care, then you could have a competitive market. You can't have a competitive market with a fee-for-service system in its fully-developed form.

Another factor that has to be considered, and that the Commission considered—well, there are two, really, that led us to consider expenditure target area: (1) The costs of medical care in this country have continued to go up rapidly, they are now at over 11 percent of GNP and they exceed that of any other industrialized country; and (2) There are many other competing demands. There are perhaps 35 to 37 million uninsured. There is a very big problem with respect to long-term care financing. We have an AIDS epidemic and a drug epidemic. And there are not the resources to continue an unlimited increase in expenditures in the Medicare program. So there have to be some limits.

Finally, we think that HCFA has to be a prudent buyer. It is one of the largest purchasers of medical care on behalf of the elderly. And in that regard, it has to act like other prudent buyers.

We believe, again, the proposals that we are making reflect that prudent-buyer concept with respect to the Health Care Financing Administration and Medicare.

Senator **Durenberger**. Just a follow-up question, and then I will yield to my colleagues.

I think what Dr. Lee says about rational choices and the patient's role is appropriate modification of where Alan Enthoven may think things are going in America today. If in fact we could make rational choices of health plans, and had enough choices and we had the financial ability to enforce those choices, then what is the view, just looking at the Commission?

What would be the view of the Commission about the impact on the ability of a good HMO, or somebody else, to actually make sure you have got an adequate supply of physicians in the underserved areas, and you took advantage of the surplus that exists in the Miami's? Isn't the RBRVS or the fee schedule an impediment to Mayo Clinic or Cleveland Clinic going into Florida and forcing down some prices in that area?

Dr. **Lee**. I can speak for the Commission with respect to the resource-based relative value scale. I can't speak for the Commission with respect to a competitive plane as envisioned by Enthoven, because we really haven't addressed that in depth. But we will be dealing with capitation more fully in the coming year.

We believe, with the proposals that we have set forward, with the resource-based relative value scale, with the practice cost overhead in the geographic multiplier, that there will be equity in payments so that the rural areas—for example, the physicians in Minnesota—would be adequately paid for what they do, would be very competitive, and that would be a more attractive market for a physician.

Now, because of the relatively higher payments in New York, Miami, Los Angeles, those are the more attractive areas for physicians, even though they are less than fully occupied.

In Table 3 we show the improvements in payments that would occur in the rural areas with respect to a national average, and in relation to the large urban areas. We think correcting those kind of inequities would create a more attractive opportunity for physicians in small towns and rural areas.

Senator **Durenberger**. Well, I think in theory you may be correct; but when you combine that with an expenditure cap, I get very frightened—especially by what happens up here in deficit time.

I also get concerned because I know there are other factors in locating one's practice in rural areas, beyond those that are obvious. I know in my State you can't get a doctor for $60-$70,000 in some small towns, even though they might be associated with a clinic; but they will go to work in the Twin Cities—or used to, at least, before things were getting too tough—they would go to work in the Twin Cities for $35,000. So, you can't do that $35 to $60,000 deal when you are paying them all the same thing, can you?

Dr. **Lee**. Well, you are not paying them all the same thing. If practice costs, for example, are higher in the rural areas, the geographic multiplier would correct for that. You are paying, for the average service, a comparable fee. The busy doctor is going to generate a higher income than the non-busy physician, so that the opportunity to earn income would be greater in those areas that are relatively underserved currently.

Senator **Durenberger**. I will come back to this again when we discuss geographic disparity, because what I am arguing are sociological and socioeconomic factors in location, and I am not sure that it is possible to factor that into an RBRVS. But I will come back to that part.

Dr. Lee. Well, there is no question that other factors—family factors, where you came from, where you trained—there are many other factors other then income that affect a physician's decision to settle in a non-urban area.

Senator Rockefeller. Senator Packwood?

Senator Packwood. Dr. Hsiao, as I look at the broad outlines of your study, it looks to me, absent some kind of expenditure targets or mandatory assignment or MAAC limits, that what you propose is a cost shifting among payments to doctors, that general practitioners will get a bit more and surgeons a bit less, generically speaking. Do I read that about right?

Dr. Hsiao. Yes, Senator, but that is only a part of it. The RBRVS will change the incentive structures and level out this economic playing field. In that process, you are going to shift some of the payments to different specialties.

Physicians will react to a change in incentives. When you pay them more to do certain services, there may be a greater supply of those services. If you pay them less, then there could be less supply, and in that sense it could improve quality as well as reduce cost; because, for example, if we have fewer unnecessary surgeries and tests, even if you pay the doctors, on the whole, the same amount of money, but, because there are fewer surgeries and tests in the hospitals, then the hospital cost could go down.

Senator Packwood. I hear what you are saying, but I think of Aunt Minnie in Baker, Oregon, who is 85. The doctor she goes to is the GP in Baker, and that GP is going to have his or her fees raised under your system. And Aunt Minnie sees that doctor a lot more than she sees the surgeon. I may be wrong, but my hunch is she spends more time with her family practitioner in Baker.

I am not criticizing what you are trying to come to. I like the idea of your change of incentives. I am not sure, in terms of Federal payment, that it is going to reduce anything. That is why I want to come to these suggested expenditure limitations, and where PPRC comes out, or the American Medical Association, or somebody else. Maybe Dr. Lee is a better one to answer this; I am not sure.

Are you both recommending expenditure targets? Or are either of you recommending expenditure targets? It looks to me like, Dr. Lee, you are.

Dr. Lee. The Commission is recommending a national expenditure target to be initiated when the transition fee schedule is adopted.

Senator Packwood. And by "expenditure targets"—let us make sure we all understand what we are saying—we say next year we are going to spend $110 billion on Medicare, and that is all we are going to spend on Medicare. And if we can't fit within that next year, we are going to make reductions the following year to make sure that we hit that target, in essence.

Dr. Lee. What we are suggesting is that there be a percentage increase, and that that percentage increase be based on practice costs, the increase percentage of beneficiaries from one year to the next, and the increase in projected volume of services.

Senator Packwood. I understand that.

Dr. **Lee**. And it is the volume part of it that is the most susceptible to the change.

Senator **Packwood**. I want to make sure we are talking about the same thing on expenditure targets. It means we will not spend over a certain amount.

Dr. **Ginsburg**. Yes, for physician services. That is right, it is setting a target for a fee.

Senator **Packwood**. I understand that, but a target on how much we will pay.

Dr. **Ginsburg**. That is right.

Senator **Packwood**. And we may have to have a proportionate reduction for all physicians to make that target.

Dr. **Ginsburg**. If we exceed the target, the following year there is a smaller fee update.

Senator **Packwood**. Okay. I just want to make sure, as the public begins to hear this and physicians begin to hear this, they understand what we are talking about.

Dr. **Lee**. Senator Packwood, we don't anticipate that the fees would in fact be reduced in the subsequent year; the rate of increase would be reduced.

Senator **Packwood**. Well, you might not envision that. [Laughter.]

But I can picture, when we are trying to narrow the deficit, we say, "You know, we spent $84–$85 billion on Medicare benefits in 1989 and next year, we would spend an additional $13 billion, absent any other factors. The President wants us to go up about $8 billion." And we might say, "To get to these overall targets, we decide to, we will simply put a payment limitation to physicians, an expenditure limitation." Now, you may not be thinking that, but I think we might be thinking that, as an overall Medicare expenditure limitation.

Let me ask you a second question. In this excellent two-page summary, "Assignment would be mandatory for beneficiaries who do not have Medigap insurance."

Dr. **Lee**. Well, we actually did not adopt that recommendation. We considered it at the Commission hearing, and those notes were made at the Commission hearing.

Senator **Packwood**. Oh. Because it is a natural out: if you don't buy Medigap insurance, your doctor has to take Medicare assignment.

Dr. **Lee**. We decided to review that recommendation, and we did not adopt the recommendation.

Senator **Packwood**. Oh, good. Because that would be a wonderful bootstrap argument: "Quit buying insurance, and the doctor has to take assignment."

Now, there are only three ways that we somehow can keep total Medicare costs down, it seems to me, other than adopting Dr. Hsiao's ideas, which by and large have much merit and deserve full consideration.

But if, as I fear, his recommendations have merit of equality but not of cost saving, we are either going to have to have expenditure targets or some form of mandatory assignment, or something congruent or similar to it, or severe MAAC limits. And when I talk about expenditures, I mean the beneficiaries as well as the Government. There aren't any other alternatives, are there?

Dr. LEE. Not that we know of. I mean, the two sources of resources for Part B are the premiums and the general revenues.

Senator PACKWOOD. Well, and the patients.

Dr. LEE. Yes, and the out of pocket. Yes.

Senator PACKWOOD. Now, are you recommending—I read your statement—a pass-through on malpractice insurance?

Dr. LEE. There are several options that we think could be considered. One is to separate malpractice out completely. The doctor could simply submit a bill for the percentage of their malpractice costs that are related to Medicare. Let us say a doctor is an orthopedic surgeon. Half of his patients are Medicare. His malpractice premium in Florida is $100,000 a year. There would be a bill to Medicare for half of that premium or $50,000.

Senator PACKWOOD. I understand that. That seems to me to be absolutely inverse to any cost saving. If the insurance company and the doctor now know they can pass along, straight through, half of it to Medicare, boy, up go the premiums. The doctor says, "Gosh, my premiums have gone up. Medicare, here is half of it."

Dr. LEE. If you use malpractice as part of the RVS, if you include it in the practice costs, there are such significant differences in malpractice premiums by geography and by specialty that we believe it must be dealt with separately. For example, a general practitioner in Utah or Idaho, or Oregon, may have a very low malpractice premium; whereas, an orthopedic surgeon in New York or California or Florida may have a very high malpractice premium. If you equalize that out, you are creating serious inequities because we think there are such differences by specialty and by geography that need to be considered separately.

Senator PACKWOOD. Oh, I understand the geography. I am just trying to figure where the limitation is, if you can pass it along. I don't care if it is in Portland, Oregon, or New York City. If you can pass it along to the Government,it sounds like World War II costs-plus contracting.

Dr. GINSBURG. Senator, that particular way of recognizing the malpractice premiums is only one of three ways. The other alternatives would calculate the fee schedule amounts more precisely, so that there was a malpractice component. That would avoid the passthrough entirely and encourage the physician to get as low a premium as possible.

Senator PACKWOOD. I have got many, many more questions, but I know the chairman does. I hope this is the first of many hearings. If we finish the other questions before 12:00, I will ask you some more.

Senator ROCKEFELLER. There will be many hearings, Senator Packwood, because there is much to be learned about this.

Just for the record, as part of your study have you done a State-by-State analysis of this RBRVS and the effect that it would have on physicians? State-by-State, as opposed to national?

Dr. GINSBURG. We haven't done any State-by-State studies. What we have done in table 3 of our testimony is evaluate the impact of the RBRVS on physicians by type of area—large metropolitan, small metropolitan, and different types of rural areas.

The results show that, with the combination of the RVS based on resource costs and the geographic multiplier that the Commission is recommending, fees for physicians in rural areas would increase substantially. In our table we show, for the large rural areas—these are the rural counties with more than 25,000 population—payments would increase about 13 percent, and for the smaller rural areas payments go up about 15 percent.

Senator **ROCKEFELLER**. I understand that. But often, when looking at rural data, for example when we were doing cataract reimbursement, you could take two rural States—Nevada is a rural State, West Virginia is a rural State, and, if you looked at charges, scales within those two rural States, they were tremendously different. One could not really come to a very rational conclusion from that. And you know, I think the point is the same here.

Senator Packwood was saying earlier that generally speaking—he asked you, and everybody was affirmative—this represents a shifting of some resources to general practitioners, so to speak, as opposed to specialties, and you agreed.

But in that there is not yet State-by-State data, one cannot assume that the degree of shift within States, or even the principle, would hold on a State-by-State basis. You cannot yet prove that; is that correct?

Dr. **BRAUN**. Let me just point out that the American Medical Association has, I believe, performed a State-by-State analysis. They did that prior to their own deliberations with respect to AMA's position.

Dr. **LEE**. We think that the Commission could do a simulation with BMAD data by charge location, so that we could produce State-by-State data. We would be very glad to try to do that.

Senator **ROCKEFELLER**. Dr. Lee, on expenditure targets, the philosophy of that is compelling in terms of the financial constraints of the Nation. In other words, we are spending $85.5 billion now on Medicare. At some point, the way things are going, the country runs out of money; we are not raising revenues; AIDS; other things that you mentioned are occurring; so that, in frustration, one can throw up one's hands and say, "Well, this will be the increase, and then the medical market system will have to work it out so that it goes no higher than this."

But in my thinking, there is no way that you can make a relationship between the principle established, were we to follow that, and the result—that is, the 500,000 or however many doctors' billings as they would add up at the end of the year. I mean, how does one possibly say, "This is the target" to 500,000 doctors? There is no system within that so that their aggregated billings at the end of the year would have any relationship to what that set target had been. Correct me if I am wrong.

Dr. **LEE**. For the individual physician that certainly is true. The aggregate target is an attempt to mobilize the medical profession to really get much more vigorously engaged with the carriers, and the PRO's within their hospital staffs to deal with the problem of volume, and to deal with what many have called inappropriate or ineffective services. There is a significant amount of care that fits into that category.

Now, I think we would ultimately like to see the targets at the carrier level, or perhaps even at a lower level, but at least at the carrier level. But that is going to take a few years.

The reason we approached this as we did was because this approach has in fact been successful both in the Canadian provinces and in Germany. The system used in Germany is quite different, but it nonetheless is an expenditure target that physicians are responsible for. Thus, they are responsible for controlling volume.

It was based on those experiences that we chose this as the least onerous of the alternatives to control expenditures.

Senator ROCKEFELLER. I understand what you are saying, but let me press my point. The AMA, you are saying—that is, physicians across the country—would thereby have to come to some kind of an agreement, some scale, some plan. Now, nobody has been able to do that before. In the case of Canada, they do it by provinces, and evidently it works.

It is unclear to me how that could be done in this country, with 50 States, and with so many doctors, on a national basis. I can see that perhaps it could be done on a State-by-State basis, and then the States would sort of come together and figure out how they matched up. But I just can't see logically how that could work.

Dr. LEE. Well, ultimately we think the State level is the appropriate level because there are organized medical units, such as State medical societies, PRO's, and carriers. Also, in many cases the carriers and PRO's are statewide.

The College of Surgeons has proposed, in their testimony before the Commission, that there be an expenditure target by specialty—in other words, a separate expenditure target for surgical services.

They recommended that in context with what they called "a blended fee schedule." They want to keep the same percentage of the pie that now goes to surgery. Then they will be responsible for the future expenditure increases.

So there are different approaches.

We realize at this time that it is somewhat of a blunt instrument to mobilize the profession, because we don't believe the problem can be solved without the active cooperation of the medical profession.

Senator ROCKEFELLER. And I understand that. The American College of Surgeons made that proposal, base payments on a blended rate, as you have indicated, that was based in part on resource input. But you, on the other hand, decided not to accept that.

Dr. LEE. Correct, because of the points that Dr. Hsiao made with respect to the current incentives with a charge-based fee schedule. Their proposed fee schedule would be partly charge-based and partly resource-based. We think, ultimately, Congress should adopt a resource-based fee schedule. Of course, we are proposing in the interim that we go with the charge-based, moving toward the resource-based fee schedule in 1992.

Senator ROCKEFELLER. The surgeons feel that the demand-side RVS could be developed in much the same way that the RVS resource-based system was developed.

Dr. Hsiao, do you think that such a development is possible? That kind of scale?

Dr. **Hsiao**. Mr. Chairman, in terms of technical feasibility, yes, you can develop that for some medical services. What the "demand relative value" means is that how much are the patients willing to pay, let us say something about the inappropriateness of patients' willingness to pay for surgical procedures? I can make my point clear by asking a rhetorical question: Let us picture that if your house is on fire, you call in a for-profit fire brigade, and the fire brigade wants to charge you x dollars to put out the fire, and you say, "I am willing to pay." Do you think that is a good and fair price? That would be a demand relative value scale for surgery.

Senator **Rockefeller**. All right. [Laughter.]

Dr. **Hsiao**. May I also wade in on the issue of expenditure cap, because there are good, valid, empirical reasons why expenditure caps should be given serious consideration.

History has taught us, based on empirical facts that competition didn't work effectively in holding down costs or improve quality, nor was regulation in the past able to hold down cost and improve quality. The reason is simple. For physician services, physicians have a strong influence over both price and the volume.

The RBRVS would deal with the price side, but it does not deal directly with the volume side. Now, you have to think, then, if you want to control costs while maintaining quality. Since physicians can influence both, how do you do it?

An expenditure cap offers really a structure for physicians to take some collective responsibility for volume. One way the profession might deal with the volume is to say, "Now, what are the appropriate services that should be performed, and what are the inappropriate services? Let's reduce the inappropriate one by peer pressure or peer control."

At this moment, we are giving physicians an open checkbook. There is no incentive or pressure on physicians as a group to take the collective responsibility on behalf of society to hold down cost or to monitor their volume and the quality of services. The expenditure cap offers an overall symbolic gesture and say, "You, the medical profession, have the responsibility to monitor each other's volume. The Congress has put a level economic playing field in place to correct the distorted incentives and you the profession should be energized and focus on the volume and quality of care."

Senator **Rockefeller**. A final question from me. I will put this to you, Dr. Lee. The Commission recommends going to a resource-based relative value system for Medicare physician payment. What would you think would happen if the resource-based fee schedule was implemented, but that an expenditure target was not?

Dr. **Lee**. I think that by 1992, when the resource-based relative value scale is fully implemented, there will be a more appropriate provision of services. In other words, it will move us in the direction of a better control on volume. But because we are recommending moving from one system to another, we believe there needs to be both monitoring of access on a continuing basis, and an expenditure target. If there is some increased volume that is unanticipated, or some overuse in some areas that wasn't anticipated, an expenditure target would help to signal the profession that that volume increase needs to be dealt with.

In the transition period before full implementation, some signal is critically important. By 1992, hopefully we could move to a State level expenditure target. In the interim we could develop the infrastructure necessary to implement that effectively.

Senator ROCKEFELLER. Dr. Ginsburg, did you want to add something?

Dr. GINSBURG. Yes. I wanted to say that unfortunately there is very little research to guide us as to what the initial effects of changes in relative values would be on the volume of services. We have heard a lot of different opinions. They are mostly opinions because there isn't the research there.

An expenditure target at the same time will act as an insurance policy for Medicare against an increase in volume due to a fee schedule. An expenditure target will protect the budget from that.

Actually, it might also protect physicians, because the actuary, for example, projected that volume would increase initially from a fee schedule and thus set the conversion factor very low, and if in fact that doesn't happen this would protect physicians, give them a more appropriate conversion factor.

So, I think that the implementation would be some of the reasons to link the fee schedule with an expenditure target.

Senator ROCKEFELLER. Senator Baucus?

Senator BAUCUS. Thank you, Mr. Chairman.

Gentlemen, as I understand the report, essentially it is to even out or straighten out some of the fees the physicians receive for the various procedures, generally.

The question I have, though, is whether your report says that you should affirmatively address certain geographic disproportion in the country—that is, whether, as an affirmative policy, fees should correct geographic disparities.

What I am getting at, more precisely, is whether this country should have an affirmative fee-schedule policy that helps reimburse doctors more fairly to keep them in rural areas. Did you specifically address that? And if so, how?

Dr. LEE. The Commission has addressed that, Senator Baucus, in several ways. In our previous recommendations to the Congress we have recommended increasing the payments for primary care, and particularly in underserved areas, and in that case specifically rural, areas. And Congress did adopt those recommendations.

The resource-based relative value scale with its correction of the present inequities would further improve that. And then, the type of geographic multiplier that we are proposing would take account of and accurately reflect the practice costs in different geographic areas.

Senator BAUCUS. And you would include the geographic multiplier in determining fees, is that correct?

Dr. LEE. That is correct.

Senator BAUCUS. Is this the geographic multiplier that was developed by the Urban Institute?

Dr. LEE. Yes.

Senator BAUCUS. Or is this your own geographic multiplier?

Dr. GINSBURG. This is a portion of that geographic multiplier. The Urban Institute had a multiplier which reflected the earnings of professionals in an area and the overhead costs in medical practice. The Commission decided not to use the former part of that index, in the sense that for the physician inputs, that would be the same throughout the country, and the multiplier would vary only to reflect prices in overhead costs for physicians.

We have analyzed what the multiplier looks like, and the magnitude of geographic variation from one locality to another is much smaller than we encounter at the present time.

Senator BAUCUS. But to what degree would you tend to refine—I guess the word I am getting at is "disaggregate" or "precisely determine"—specifically different fees for different doctors in different parts of the country?

For example, when you talk about rural America, with all deference to my colleague from West Virginia, rural West Virginia is a little bit different than rural Montana, certainly rural Eastern Montana.

Are you recommending that Medicare reimbursements be so precisely defined that a general practitioner in rural West Virginia would get the same as, or would he receive a fee different from, that same GP for the same procedure in Baker, MT?

Dr. GINSBURG. Under our geographic multiplier, the fee in those two rural areas would not be exactly the same. I would be surprised if they would be very different, though, because they would be based on an index of office rents are, say in Montana versus the rural part of West Virginia and what wages are for nurses and the clerical employees that work in the physician's office. And on that point we mostly——

Senator BAUCUS. We don't have a lot of time, but let me tell you a little bit of my experience. I brought Dr. Roper to Montana a couple of years ago. We visited some very rural hospitals, and I was struck with the intensity with which the hospitals administrators and the physicians told me how much more they had to pay nurses and other people to attract them to that rural hospital, because that same nurse, that same person, could receive a much higher salary, in nearby say Billings, Montana, which is a large city in our State. That is just anecdotal, but several people had that point of view.

But it hit me very solidly as to how much more they had to pay to attract people to come. So, I suggest that you not only fold out the charts and see how much utility bills are for Baker, Montana, but also look at the practical realities and how much more you have to pay to attract health professionals to come.

Dr. LEE. We would look at wages, but it would be by carrier area. In other words, it is pretty hard to fine-tune it to one small town versus another, let us say in rural Montana.

Senator BAUCUS. That is the question I asked.

Dr. LEE. I don't know, Paul, could we go below a carrier area?

Dr. GINSBURG. Well, actually the decision as to where to draw the boundaries of these areas is something that the Commission said needs to be done; we need to have the same philosophy behind all of the boundaries. But we didn't make a specific recommendation as to how to do this at this point.

Now we have some States where the entire State is a locality, and other States which draw the boundaries very differently. We think that there ought to be a uniform policy.

I think a lot will depend on the nuts and bolts of what data you can get. In other words, we would like to do it as precisely as possible. I doubt that there is a statistical source that could give us an index for Baker, MT.

Now, perhaps the index could be not for all of Montana, but perhaps for various regions in Montana.

Senator BAUCUS. Let me play devil's advocate just for a minute here. What about the Canadian system? That is, if we are going to try to get some limit on Part B reimbursement, somehow, at the same time we want to make sure that it is a right amount, it is fairly distributed among physicians. As I understand the Canadian system, the Government of Canada negotiates a certain amount that it pays physicians per province, and then the physicians within the province can decide among themselves as to what is the most equitable way of doing that.

Now, I may be totally off base in describing the Canadian system, but that is what I understand it to be.

Dr. LEE. It differs by province. There is a negotiation between the medical profession and the provincial government. The government ultimately decides how much will be allocated for physicians' services. Hospitals, of course, are dealt with separately.

The relative charges are usually determined by the medical profession, but they go from a base. The current relative values are a modification of those adopted when the government medical insurance first went into effect in the early seventies in Canada. The provinces basically adopted what were the fee schedules that were in effect in the equivalent of Blue Shield insurance programs in Canada. From that base they have modified them every year; there is an annual update. So that if one group of specialties increases substantially, they might make a modification and lower their rate of increase versus a more rapid increase for another specialty.

For example, when we were in Alberta, they were going to raise the cardiac thoracic surgeons' payments, because they felt that they were falling behind other specialties that they were comparing them to within and outside their province.

Senator ROCKEFELLER. Senator Baucus, I have to cut in for a moment, because we are about to have a vote on the nominee for Secretary of Defense, and I want to get back to Senator Durenberger and Senator Packwood. So, would you forgive me?

Senator BAUCUS. All right.

Senator ROCKEFELLER. Senator Durenberger?

Senator DURENBERGER. Thank you, Mr. Chairman.

This is a follow-on, which might allow somebody else in the discussion.

For sake of discussion, let us assume the United States chooses not to go the Canadian route but chooses to go to universal coverage for every American through health plans. Each person would purchase a plan, selects their own providers which provide managed care and pays the providers some price for their services.

It seems to me the choices we have before us here are that price is either going to be a fee schedule, because everybody is going to get excited about your recommendations, and every third-party payor and every health plan is going to adopt them, or it might be or a variant on it or something else entirely.

I am bothered, only slightly, by the way we all smile when Dr. Hsiao gives us the example of the for-profit fire brigade, because that is the way we are used to thinking in America. I mean that for-profit service means that you are going to have to pay something, and they might hold you up, and that sort of thing. But the reality is, everybody in this country buys fire insurance on their home, and they buy it for the most part, from for-profit insurance companies.

The problem in this system is that those for-profit insurance companies earn a profit for doing nothing other than paying, in many cases, grossly exaggerated costs for fire services, very few prevention services exist without a lot of incentives, all across this country.

We don't know what the real cost of fire insurance ought to be. We just pay it. Because, except for some place in Arizona, there aren't any for-profit fire brigades going to a community and saying, "Tell you what we can do for you: For the people in this community, we can do more prevention and better service for lower than you are paying your government-run fire brigade."

Now, that is the thesis that I present to you when I suggest an alternative to your plan, which may be that we use the fee schedule as a basis for negotiating with providers all over this country. We must think about it in terms of sort of a regulatory clout mechanism that we have to hold over people's heads, so that we can negotiate fees on a State-by-State basis with a variety of providers.

If I am correct in my assumption, we are going to have health plans out there doing this for us. Those health plans could go into a State like Florida, for example, and armed with some kind of a national fee schedule, they could say to the State, the people in Florida or the health providers that want to do business in Florida, "As long as you stay within this overall expenditure cap, and you use some variant on these fee schedules, we are going to let you decide which doctors in which part of Florida get paid above the fee schedule and which get paid below the fee schedule."

I now come back to Egdahl's theory of access, because we know there is a lot of surplus in a place such as Florida, and we know that there are some shortages in a place like Florida.

If you let a system work with Florida, where the health plans can go in and negotiate some differences around a basic fee schedule, might that not be a way to use your proposal and your theory of tax expenditures to overcome some of the concerns about access?

Dr. LEE. I will have to speak personally, because the Commission hasn't dealt with the issue in just that way. But if there was universal coverage, I do not believe that the proposals that we are making would in any way impair the movement as you describe it. The expansion of HMO's or competing health plans would not be impaired by the proposals that we are making.

Dr. GINSBURG. I would like to say that now we have 97 percent of the Medicare beneficiaries that are not in HMO's or CMP's, and this fee schedule is for them. It is for that care. I personally would like to see more of the Medicare beneficiaries in managed plans, and if I thought that the fee schedule would impair that, I wouldn't be happy about that.

I am not aware of any impairment now. If any turned out, I think adjustments could be made to preclude that.

In a sense, I guess the country has gone through a period of enthusiasm about managed care. I think the enthusiasm is still there, particularly in the private sector. It has been frustrating that the Medicare program has not been able to get as much involved.

I see that we can really pursue two tracks: do what we can to make the managed-care alternative in Medicare work better, but not neglect what today are 97 percent, and hopefully tomorrow won't be so high, of the Medicare population still in fee-for-service.

Senator ROCKEFELLER. Dr. Braun?

Dr. BRAUN. I would like to address myself to this, also, because as a physician I am concerned with a concern that you expressed, that this might just be another regulatory approach, and that we might end up with the dead hand of regulation over medicine.

But I think we really have to acknowledge that we already have a great deal of regulation, and we have in place a system of fees that have been frozen.

Our research has found that those fees, as frozen, are not in accord with what physicians believe the work and the resources are to do them, and so some kind of change is reasonable.

I think the way to look at resource-based relative value research is that it is a very useful tool. Only one application is a single fee schedule. And the tool might be used as you have suggested, as a basis around which providers and payors can negotiate.

We haven't measured everything precisely to the third decimal point. We haven't looked at these very important consideration—of differences in quality of care, of expertise, the amount of compassion that individual physicians may provide, or how available they are. So, I think this should be viewed as part of a more flexible way of looking at how to pay physicians.

But it does have the great virtue of reflecting better what physicians believe to be the important determinants of at least the cost side of things. I think we also can look at it, then, as part of a pluralistic system, where we have different carriers, different ways of approaching the organization of care, and that is likely to remain.

So, I can foresee physicians and provider organizations negotiating about different conversion factors to arrive at different prices, that this is not simply a rigorous system but is a very useful set of information around which people can make decisions and set up a structure that is more consistent with at least what physicians believe to be important parts of pricing.

Dr. LEE. I think it is also important to note, in the study that Dr. Hsiao did, that within each specialty it was the specialists themselves, the cardiac surgeons or the ophthalmologists, who made the recommendations for their particular specialty.

Senator DURENBERGER. Mr. Chairman, let me say that one of our colleagues, Senator John Heinz, probably hasn't missed one of these hearings in the 12 years that he has been here. He was called out of town today unexpectedly. He does have both a statement and a series of questions that he would like to propound to the witnesses. I also have a variety of additional questions that I will submit in writing for the record, as well.

[The questions from Senators Heinz, Durenberger, and other Senators appear in the appendix.]

Senator Rockefeller. Senator Packwood?

Senator Packwood. Dr. Lee, we all know in our respective professions people who are better and worse than the average. In the Senate we know who the better Senators are, among ourselves. Clearly, when I practiced law, we knew who the best lawyers were, whether it was a commercial case or a trial. And you know, by and large, in the medical profession, in a local area, who would be good and bad.

Is the reason that you don't attempt to differentiate and to reward competence is that you simply can't? It can't be that you can't "know it," because you do know it. You can't measure it? Or what is the reason?

Dr. Lee. Well, I think in terms of the payment, the reward for that competence comes professionally. It comes from the respect of your colleagues and often because of greater referrals. The surgeons, for example, are busier surgeons; the better internists are busier internists. So I think the rewards are not in the price for the individual service that is provided, but rather for these other elements. There are some economic rewards.

Senator Packwood. Psychological rewards, you mean.

Dr. Lee. They are professional. Absolutely, they are very, very important, and I would say more important than the economic rewards.

Senator Packwood. They are important in all other professions, too; but there usually comes a remunerative reward in addition to the satisfaction that your peers know you are good.

Dr. Lee. Well, I would say that it is the volume. When you are an outstanding physician, and it is recognized by your peers, you are going to get more referrals.

Senator Packwood. That I understand.

Dr. Lee. And that leads to a greater income, as well.

Senator Packwood. Dr. Hsiao, go ahead.

Dr. Hsiao. No, I don't mean to interrupt you. Go ahead.

Senator Packwood. I understand that. In the private sector, if you are a really good surgeon, you have more referrals, and you will make $200,000 or $300,000. And one that isn't busy will make $100,000.

But you are saying, from a Medicare standpoint, that competence is not going to count, that we are going to pay the competent surgeon as much as the incompetent surgeon, assuming that the person has not had his license yanked.

Dr. Lee. Well, the balance billing is one that gives you some room for that option.

Senator Packwood. The balance billing. But you are going to get rid of the past history and the usual and customary fees, and all of that, as I understand it.

Dr. Lee. Right. But now there are gross inequities, and we don't necessarily pay the best surgeons, certainly in the Medicare program, higher fees.

Senator Packwood. No, I understand that.

Dr. Lee. So, I think we would see this as a fairer system. At the present time we don't have good methodology that lets you put the quality component into that price. We do think it goes on the utilization and the volume side. That is where we are looking at quality. There is no way that we know, as yet, to do that on the price side. If we could do it, I would have no problem with doing that; but I just don't see any way to do it at the present time.

Senator Packwood. Thank you.

Let me say, Mr. Chairman, this has been an extraordinary panel. The amount of work that you people have put into this is mind-boggling, and I think you are leading us in the right direction. I have less faith than you do, that it is going to end up in reduced costs, but I think it is going to end up in fairer payments, and that is a step in the right direction.

Thank you, Mr. Chairman.

[Additional questions from Senator Packwood appear in the appendix.]

Senator Rockefeller. And thank you, Senator Packwood.

The vote is now taking place, so we will need to conclude this.

I agree with Senator Packwood very much, and the amount of work is extraordinary. I would also have to say, however, that I think it is incumbent upon those of us on this Subcommittee to approach your work skeptically, that there are still many questions to be answered. When a witness, as you did, Dr. Hsiao, comes forward with 2000 pages, and then a number of them address criticisms that have already been made to your study, I think that warns all of us that there is a danger in playing God. Yet, when it comes to that portion of physicians' fees which come from Medicare reimbursement, in a sense the Congress does play that role.

So, the need to make fair judgments and to be skeptical and to be sure, before we act, about the effects on different types of physicians as well as on different parts of the country is really important.

Just as mistakes have been made in the past, mistakes can be made even with bold new plans. It is exciting, it is important, it holds the promise of something really new and really beneficial; but then, again, we are only beginning this process, and I just want to add that note of caution as my own philosophical approach.

I think this has been an excellent panel, an excellent beginning. We will see certainly more of you, Dr. Lee, and I would hope also, Dr. Hsiao, yourself as well as your colleagues. Thank you for being here.

The hearing is adjourned.

[Whereupon, at 12:08 p.m., the hearing was adjourned.]

PHYSICIAN PAYMENT REFORMS

THURSDAY, APRIL 20, 1989

U.S. SENATE,
SUBCOMMITTEE ON MEDICARE AND LONG-TERM CARE,
WASHINGTON, DC.

The hearing was convened, pursuant to notice, at 2:00 p.m., in room SD-215, Dirksen Senate Office Building, Hon. John D. Rockefeller IV (chairman of the subcommittee) presiding.

Also present: Senators Baucus, Chafee, and Durenberger.

Senator **ROCKEFELLER**. This hearing will come to order. I am delighted to welcome Senator Hatch.

Senator, I think that our States have some matters in common. We are counting on you Senator, particularly with respect to Medicare payments for physicians. When doctors know they are not going to get as much they tend not to come to our States and I think that is something that we share in common. And you, of course, have tremendous expertise in the health field. I welcome every word that you have to say.

Senator **HATCH**. Well, thank you, Mr. Chairman. I appreciate those kind remarks.

Senator **CHAFEE**. Mr. Chairman, I have a statement I would like to put in the record.

Senator **ROCKEFELLER**. Senator Chafee, if you do not mind, I have kept the Senator waiting. I am withholding my own statement until he is finished and then we can both give statements. Is that fair enough?

Senator **CHAFEE**. All right. Sure.

Senator **ROCKEFELLER**. Okay.

Senator **CHAFEE**. Fine.

OPENING STATEMENT OF HON. ORRIN G. HATCH, A U.S. SENATOR FROM UTAH

Senator **HATCH**. Thank you, Mr. Chairman and Senator Chafee. I am pleased to have this opportunity to testify before the Subcommittee on Medicare and Long-Term Care regarding physician payment reform. Specifically, I believe that we have a geographic inequity that is harming both the provider and the patient in my home State of Utah, and I might add in other States such as yours, Senator Rockefeller.

The current Medicare reimbursement system for physicians has evolved over a number of years and has arrived at a place that no one intended. We now have a reimbursement system in which physicians providing exactly the same service are reimbursed at very different levels depending on whether the office is on one side of the State line or the other.

Let me just point to these graphs on physician reimbursement rates. The red is Utah; the blue is Idaho; green, Montana; dark green, Wyoming. As you can see Utah falls below in every one of those categories except brief service delivered in the hospital where Idaho is just slightly behind it by 10 cents. I think that this graph really does tell the story of the inequities that exist just among our Western intermountain States, that is, those States surrounding Utah. Physicians in neighboring States receive up to 20 percent more for services provided in office than do physicians practicing in my home State of Utah. For physicians providing hospital care, on the second half of that particular chart, this discrepancy can be as high as 33 percent.

I know the members of this committee will carefully consider the information and recommendations provided by the Physician Payment Review Commission (the PPRC). The Commission recently completed a study of geographic variations in Medicare charges and reported their findings to Congress in March 1988. This report states that prevailing charges may vary extensively from one locality to another and confirms that payments to Utah physicians are below payment rates in other States. Mr. Chairman, I would ask that this table of these findings entitled "Distribution of Prevailing Charges for Selected Procedures and Specialties" be included in the record.

Senator ROCKEFELLER. We will put the entire chart in, Senator. [Laughter.]

Senator HATCH. I want to keep my chart.

Senator ROCKEFELLER. Oh, okay.

Senator HATCH. I will provide you with one. [Laughter.]

No, no. We will be happy to put that in the record if that is what it takes.

[The chart appears in the appendix.]

Senator HATCH. This table shows that all of the Utah prevailing charges are below the national mean. In addition, prevailing charges in Utah for some of the services compared are near the bottom of all charges in the United States.

The PPR Commission looked at factors that could explain and justify these geographic differences and concluded that the cost of practice differences accounted for some of the variation, but certainly not all. This conclusion is further supported by a study completed by the Utah Medical Association which indicated that the actual costs of practice, including such items as malpractice insurance, employee expenses, office rent, and supplies are not substantially lower in Utah. In many cases, the costs are actually higher in Utah than in the surrounding States.

Unfortunately, when our current reimbursement mechanism was created over 15 years ago, it highlighted the differences in practice costs between States. In addition, these State differentials were frozen at those 1973 levels because the law limited percentage increases in out-years and applied this limitation to all States equally. Thus, over time, arithmetic increases in payments have been considerably greater in those States which started with a higher base, compounding the problem, of course, with each passing year.

States like Utah, which had low fee structures in 1973, have been penalized ever since for their conservative charges at the time. We are punishing those physicians who were cost conscious in delivering services, or efficient in doing so.

I am concerned about this system of inequity in Medicare physician reimbursement, Mr. Chairman, but I am more concerned about what these inequities are doing to the quality of healthcare in Utah and other under-reimbursed States. In the same report, the PPR Commission went on to state that the "the wide variation in charges unrelated to differences in cost of practice could mean access to care and beneficiary financial protection might be compromised in areas where prevailing charges are low."

This is happening in Utah right now, Mr. Chairman. I have been told that physicians practicing in Utah are moving their practices to neighboring States with higher reimbursement rates and I fear that young physicians may decide to avoid practicing in Utah all together. If this trend continues, many seniors in Utah—and we are a large senior State—may have difficulty finding a doctor when they need one.

Compounding this trend, more and more physicians who remain in Utah are reluctant to accept assignment of Medicare patients. Can you really blame them when physicians with similar practice costs across the State line are receiving 20 to 30 percent more for exactly the same services? In turn, because there are fewer participating Medicare physicians in Utah, our elderly are faced with higher out-of-pocket costs for their healthcare.

When this pressure on primary care providers and their patients is coupled with the reimbursement pressures that are forcing many rural hospitals to close their doors, I think the future of access to healthcare in Utah may be in jeopardy—and I intend to do everything I can and use every possible power that I have to stop this. I want to work with all of you to ensure that our Federal laws do not continue to wreck havoc in our healthcare delivery system.

In addition to reducing access to healthcare, inequitable State reimbursement rates often place unfair burdens on the non-Medicare patients of these providers. Physicians who do remain in Utah—and are reimbursed below cost—face no other alternative other than to increase their charges to other payors.

At the same time Utah Medicare beneficiaries are subsidizing beneficiaries in wealthier States. All Americans, regardless of their residence, are subject to the same Federal tax and social security liability. All Medicare enrollees pay the same premiums for Part B coverage. Yet, there is not—under our current system—equal distribution to the providers serving these seniors. Taxpayers in some parts of the country, like Utah, are subsidizing citizens living elsewhere. Ironically, in the case of Medicare, more prosperous sections of the country tend to be subsidized by dess prospergus ones. That is a big probdem, I think&

Mr. Chairman, I am firmly committed to eliminating the inequities in the Medicare physician reimbursement rates. When the Senate reconvenes in early May, Senator Garn and I will be introducing a resolution expressing the sense of the Senate that the problem of geographical variations must be addressed and that the present inequities be eliminated in any mechanism for Medicare physician reimbursement. I would urge you and your colleagues to co-sponsor this resolution. The entire Utah delegation urges you to carefully consider the issue in your deliberations on physician payment reform.

Finally, I just want to tell you I appreciate this opportunity to testify this afternoon, Mr. Chairman. I know that this committee faces a monumental task in physician payment reform. There are many possible solutions to this pressing problem, such as allowing those States who have been harmed by under-reimbursement to rise above the cap and receive a greater annual increase than other States. This approach would allocate a disproportionate share of any increase in physician payments to those States with the lowest rates. We may also want to consider a national rate for physician reimbursement, or a plan that would re-calibrate State reimbursement rates based on today's practice costs.

I am anxious to help this committee in any way possible to identify an appropriate solution to this critical problem. These geographical inequities must be eliminated if we are to protect the availability of quality care in America.

I want to thank each of you for listening to me and I hope that you will help us in my home State as well as other States who are similarly situated to resolve these very serious problems.

Senator ROCKEFELLER. I think we want to. I hope, at least, that you can be somewhat reassured by the fact that the fee schedule that was recommended by the PPRC would substantially reduce those geographic discrepancies that concern both of us.

Senator HATCH. Thank you.

Senator ROCKEFELLER. Thank you very much, Senator Hatch.

Any other questions?

I think Senator Durenberger has one.

Senator DURENBERGER. Mr. Chairman, just, I guess, a comment to my colleague from Utah.

First, I wish I could speak to my fellow colleague from Minnesota, but put me down as a co-sponsor on your resolution right off the bat.

Senator HATCH. Well, thank you. I appreciate that.

Senator DURENBERGER. I think you will get at least 64 of us right off the bat because there are 32 States below the national average. Whether we can get the 20 States—that will leave 20 Senators trying to justify their——

Senator HATCH. Yes, I did not want to say it, but I really believe there is room to change this process.

Senator DURENBERGER. Yes, it is—but I am sure it is the most difficult undertaking. I suppose part of what we addressed here at the first hearing we had and on this one will be how to do that without increasing volume. That is the struggle that I think you appreciate because you have been at this longer than any of us.

Senator HATCH. I do.

Senator DURENBERGER. That if we just put some kind of a national average across everybody and bring down the folks from the ten States, all they are going to do is see twice as many people, if there are not some other restraints in that systems. And so every argument that I heard you make in the statement—while it has to be a succinct statement—it is being repeated all over the country, and particularly the disparities between the rural parts of your State and Salt Lake City, for example—or the rural parts of my State and the Twin Cities.

We are very conservative like you are in Utah in both areas, but the capacity to pass the extra cost off on third-party payors does not exist in rural Utah and it does not exist in rural West Virginia, and it does not exist in my State.

Senator **Hatch**. That is right.

Senator **Durenberger**. The big companies, with the big insurance plans, are not out in the rural States. The people that do not have insurance coverage are out there in greater numbers so there is no place to pass these extra costs onto. That is why the physicians in rural Utah and West Virginia and Minnesota are deciding not to, you know, when they want to retire, they retire, and nobody wants to go out there and practice anymore.

Senator **Hatch**. That is right. I agree. It is going to hurt the health delivery process throughout the country if we do not do something about it. So it is just something we simply have to cure.

I appreciate the good faith intentions here and I will be really doing everything I can to help you, Mr. Chairman, and other members of the committee to help change this and to make it equitable. I do not want to hurt other States. I don't want to hurt the States that have an advantage right now in the sense of taking away or reducing what they have coming in. But on the other hand, it is clearly inequitable and it is clearly wrong and clearly out of balance.

Frankly, we get penalized in Utah because we generally are very efficient in operation of all programs and in so many other ways we get penalized for our very good efficiency and conservative approaches.

Senator **Rockefeller**. Thank you, Senator.

Senator **Hatch**. Thank you.

Senator **Rockefeller**. Before we have our next witness, we will accommodate those who want to give opening statements, including myself, but we will start with Senator Chafee.

Senator **Chafee**. Mr. Chairman, I will just put one in the record at this time. Thank you.

Senator **Rockefeller**. That is it?

Senator **Chafee**. That is it.

Senator **Rockefeller**. You've only got one page there. It would not take long.

Senator **Chafee**. Well, I do not want to encourage others. [Laughter.]

Senator **Rockefeller**. That does not discourage me at all. Senator Durenberger?

Senator **Durenberger**. No, thank you, Mr. Chairman.

Senator **Rockefeller**. SENATOR BAUCUS?

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA

Senator **Baucus**. Thank you, Mr. Chairman.

I do though want to say that I would like to co-sponsor the resolution of the Senator from Utah. It is another in a series of efforts that many of us in the Senate have been taking.

I commend you for this hearing. I hope we find solutions. I do have a statement that I will include for the record.

Senator Rockefeller. We'll include it for the record and you're going to hear mine.

OPENING STATEMENT OF HON. JOHN D. ROCKEFELLER IV, A U.S. SENATOR FROM WEST VIRGINIA

Senator Rockefeller. In our first session—this being our second—we reviewed the findings as most of you remember of Dr. Hsiao's impressive research on a resource-based relative value scale and heard for the first time the recommendations of the Physician Payment Review Commission for Medicare reform on physician payment. The Physician Payment Review Commission recommended that Congress should move forward on a resource-based relative value scale and begin to implement a transitional fee schedule as early as next spring.

To protect beneficiaries, PPRC advocates a policy of mandatory assignment for all services provided to low-income persons and a policy to limit balanced billing to other beneficiaries. Finally, PPRC would address the problem of volume growth within the Medicare program with a policy of expenditure targets, coupled with practice guidelines and utilization review.

Today we have invited beneficiaries and the physician community to respond to these recommendations. I expect discussion will be lively and I look forward to them. However, I hope the committee will not be overly preoccupied with the question of winners and losers. The primary purpose of this physician payment effort is not the redistribution of physician income. Our aims, rather, are to develop a more rational system of paying for physician services—a method that is less complex, a method that provides an appropriate level of economic incentive for important services such as primary care—to ensure fair reimbursement for doctors, no matter where they live and what they do, to ensure access to quality healthcare for our Nation's elderly, and to explore ways to get a handle on out-of-control Medicare spending for Medicare part-pay services, that being about 15 percent per year.

These are not small tasks and that is what we will be about today. Mr. Frank Delay—I will give it a French pronunciation because I do not want to say delay—you are on the Board of Directors of the American Association of Retired Persons and you are from Mesa, AZ. We welcome your testimony.

STATEMENT OF FRANK DELAY, MEMBER, BOARD OF DIRECTORS, AMERICAN ASSOCIATION OF RETIRED PERSONS, MESA, AZ, ACCOMPANIED BY STEPHANIE KENNAN, LEGISLATIVE REPRESENTATIVE, AARP

Mr. Delay. Thank you, Mr. Chairman.

As you said, I am Frank Delay, a member of the board of directors of the American Association of Retired Persons. I am accompanied today by Stephanie Kennan of our Federal affairs staff.

We appreciate this opportunity to present our views on physician payment reform. My written statement outlines in detail our reaction to the Commission's report. I will outline the key points today.

First, we begin with the premise that the purpose of Medicare is to provide beneficiaries financial protection for access to needed health services. Payments to physicians are a means of achieving that end.

Second, AARP continues to support a resource-based relative value scale. However, it is critical to remember that any change in payment rates, even if budget neutral in the aggregate, means beneficiaries will be affected differently. Simply put, I do not visit a doctor in the aggregate; I have specific medical needs, and I visit specific doctors. I will need to know how changes in payments will affect me.

For example, raising payment for primary care services may encourage doctors to perform more primary care. But my co-insurance will also raise. How will this impact my access to care?

Third, AARP recognizes that volume is the key issue. While some state that beneficiaries are responsible for the increase in volume, I would like to state that the doctor and not the patient is the decision maker concerning what services will be performed. The number of office visits per beneficiary have remained stable over the past decade. Out-of-pocket or Part B services paid by beneficiaries in the form of premiums and co-insurance is increasing, in part because of the increase in volume of services.

Part B premium has risen 91 percent since 1984. Co-insurance is now over $7 billion, having increased from just over $2 billion in 1981. The impact on the beneficiary must be beneficiary must be understood before reforms are adopted. AARP strongly supports PPRC recommendations for further research and the development of practice guidelines as one method to control volume. Determining what is affective care is essential before moving forward with other steps to control volume.

Another approach favored by PPRC is a national expenditure target. AARP approaches the concept of expenditure targets cautiously. The concept of that particular target as proposed by PPRC is a useful one. However, AARP has many questions, such as how will the target be implemented, who will set it and will the cost—will it create cost shifting to the non-Medicare purchasers of healthcare as you just discussed here.

From the beneficiary perspective, volume must be controlled and beneficiaries will want to be a part of further discussions about expenditure targets.

Fourth, we support recommendation concerning monitoring access to care and the impact on beneficiaries. This is crucial to any reform system. This information will be vital in refining payment systems over time and in ensuring that we meet our goals of providing financial protection and access to care.

Fifth, PPRC recommends a transition of 2 years. We believe that any change in payment system should be implemented over a transition period of at least 5 years to avoid abrupt changes for providers and patients.

Sixth, the beneficiary protections are important to prevent cost shifting to beneficiaries. We strongly support the continuation of the pilot program and balance billing limits as PPRC recommends. But we view these as transition steps towards mandatory assignment. Once fair and rational fees are achieved, why should a physician be permitted to balance bill any patient for what is above and beyond a fair fee.

We applaud the Commission for recommending that physicians be required to file patient's claim forms with Medicare. This step is important in streamlining the system for beneficiaries and assuring that they receive the benefits to which they are entitled.

Finally, Mr. Chairman, we realize that pressure to reduce the budget deficit will continue in the years to come. While budget considerations were not part of PPRC's mandate, we urge you to keep this pressure in mind as you design a new payment system. The new system must be able to withstand attempts to achieve budget savings without harming the integrity of the system.

Thank you.

[The prepared statement of Mr. Delay appears in the appendix.]

Senator ROCKEFELLER. Mr. Delay, I appreciate your testimony and you are clearly concerned. When you talk about 5 years as a transition, that is very definitely a substantial amount of time. Obviously we have to have as much data and analysis as possible. You do not want either the beneficiaries or providers to be somehow dislocated——

Mr. DELAY. That is right.

Senator ROCKEFELLER [continuing.] In what is this incredible experiment.

On the other hand, you have also testified rather definitively that our present payment system is badly flawed. So one is left, then, with this in between land—the longer we wait, the longer these flaws will persist. Given then the trade off of that, do you think that there is a case for starting to slowly implement RBRVS next year, perhaps with some limits on balance billing while carefully monitoring its effects?

Mr. DELAY. We think that we should get started as soon as possible, that is right. But we do feel that we are not at all sure what the affect is going to be on both the recipient and the provider and that that is why we recommend a rather cautious approach.

Senator ROCKEFELLER. But it is a very cautious approach. That is what I am trying to get you to elaborate on. If the present system is seriously flawed—and there is really nobody that disputes that—then 5 years is a very long time. Ordinarily, if one works in a transition over that period of time something could be changed on the way. Pressure may build for amendments, you know, as we are seeing with catastrophic. If you allow things to percolate, they do not always percolate in the direction that you want them to percolate.

So I just challenge you with the idea of trying to start it next year slowly and then monitor. Now, tell me what is wrong with that?

Mr. DELAY. I find nothing wrong with that, Mr. Chairman.

Senator ROCKEFELLER. Well, but you do in that you are asking for five. I am trying to get——

Mr. DELAY. Well, we did not want to 5 years to start—maybe I gave the wrong impression.

Senator ROCKEFELLER. No, I understood that.

What about 1 year? We start in a year.

Mr. DELAY. Yes.

Senator ROCKEFELLER. Which you would agree with?

Mr. DELAY. Yes.

Senator ROCKEFELLER. But then monitor it closely.

Mr. DELAY. That is right.

Senator ROCKEFELLER. That is okay with you?

Mr. DELAY. We had hoped—that is why we were suggesting the longer term—that we would have an opportunity to monitor it as it developed.

Senator ROCKEFELLER. You want to have a chance to come back in should problems develop?

Mr. DELAY. That is right.

Senator ROCKEFELLER. Fair enough.

Also, do you have any information on the implementation of the Qualified Medicare Beneficiary Program?

Mr. DELAY. We feel that if the recipients are considered as Medicaid recipients, then they should be treated as Medicaid recipients and that they would receive the same treatment as other Medicaid recipients. I think that is the problem, how they are classified.

Senator ROCKEFELLER. Do you have any specific suggestions for strengthening this program?

Mr. DELAY. We would like to have an opportunity to get back to you in writing on that question.

Senator ROCKEFELLER. Very good.

Could AARP support a limitation on balance billing for low-income seniors if this policy were part of a larger phase-in of an overall policy to limit balance billing for everyone?

Mr. DELAY. We are in favor of limiting balance billing, definitely. We hope that eventually we will work towards a program in which there is no need for balance billing because everyone—the fair rate of pay is determined and that is what everyone pays. So I think I would agree with you that as we develop it we would go along with a limitation on balance billing.

Senator ROCKEFELLER. All right. Now AARP is not ready to endorse expenditure targets because you do not know what the impact is going to be. Fair enough?

If not expenditure targets, what policies does AARP advocate to control the volume of Part B services?

Mr. DELAY. We feel that there is a very definite need for a control of the volume. That is one of the concerns that we have. We hope that by establishing fair fees that that will have one effect of automatically starting to control the volume. The implication, I think, is that the providers are increasing volume because they do not feel that they are getting enough income.

Senator ROCKEFELLER. Would you be willing to think through that whole question further and come back to this committee with some thoughts on that?

Mr. DELAY. We certainly would, yes.

Senator ROCKEFELLER. Senator Durenberger may have some questions.

Senator DURENBERGER. I will just start with the note you just got handed. I think that is very appropriate, to begin by thanking

AARP for its stand on catastrophic insurance. I found that in particular when Senator Rudman and I were the only two people to vote against this resolution last week. When you get down to only two people it looks terribly symbolic and it should not reflect on a lot of the other people. I think it is one of those things in which it was an innocuous enough resolution so that people could support it.

But at some point in this whole area of how do we—I mean, Medicare as you point out in your statement is the health insurance for the elderly in this country—33 million people. At some point somebody has to stand for principle and I think that is what AARP did——

Mr. DELAY. We hope so.

Senator DURENBERGER [continuing.] In that whole process. I would suspect that over time we will all learn that there were some elements of that bill that were long term care elements that are being financed as though they were catastrophic and maybe some changes can be made. But I think the fear that everybody here has is that if we do much more than hearings this year, that thing gets opened up and a few people—not necessarily on behalf of all elderly—are going to throw away and awfully good thing.

It bothered me as we watched that bill pass that the people who voted against it were the folks who said, this will never last. It will never last. Within a year it will be all over with and they will be back into sort of general taxation. So when an organization that represents now, what, 27 million or 28 million Americans is willing to stand up and say——

Mr. DELAY. About 30 million, I believe, now.

Senator DURENBERGER. I mean, if you are willing to stand up and say those people are wrong, I mean, we can be generationally responsible in this area, then I think we need to do our best to support you.

My question is also a volume question and I do not know that it needs an immediate response today, but it relates to catastrophic. One of the promises that we made, all of us who were going back talking to our constituents—those of us who, you know, were committed to making catastrophic a part of Medicare—we all said, now when you get catastrophic, like I said to my mother and father, you know—once you have catastrophic in there you can stop buying all the rest of the supplemental stuff and the prices of all the supplemental stuff is going to go down.

Well, now we know the prices are not going down and when you ask the health insurance folks why they are not going down, they say, well, because all the costs are going up. I think part of the reason is because my mom is still buying that insurance; and also because you are still selling it at AARP. [Laughter.]

So maybe one of the questions that, during the course of these hearings, as they relate to volume, which the Chair has already raised, maybe one of the questions we could be dealing with is, is there a way to encourage my mother and father and other people who are over 65 to be wiser purchasers of supplemental, so that if we can discourage people from buying insurance that just covers their co-pay, you know, that sort of thing—or just covers their deductibles—when they can afford to pay those deductibles, then maybe we would force the insurance industry, including whoever—I guess I know who works with AARP—to gradually bring those prices down. The key seems to be to get my mother to stop buying a policy that just covers things she can pay for.

Any thoughts over time you can have on that subject I am sure would be very helpful to us.

Mr. DELAY. I am not prepared to say what the future will hold on that. We do not recommend that people immediately stop using the supplemental insurance. I think that they are going to have to study and find out just exactly what is covered and what they can afford to pay. I have read some statements to the effect that, as you say, if the individual can afford to pay his own section of the 20 percent, then perhaps he does not need to have insurance on it.

But in my own experience in the last several years, the insurance has been a lifesaver. My wife and I have been unfortunate in that in 1987 we had a $20,000 medical bill and in 1988 we had a $25,000 medical bill. If it had not been for the supplemental insurance, I would be financially in trouble.

Senator DURENBERGER. But now, thanks to AARP and the Congress, you know, in large part that $20,000 bill has been covered through catastrophics.

Mr. DELAY. That certainly will be a help.

Senator DURENBERGER. So I think it would be wonderful if some of us could pick up Modern Maturity one of these days and in addition to the adds for your insurance we could also see a well thought out article that said, people, those of you who are situated such and such probably ought to think twice before you buy our insurance. That would be good.

Mr. DELAY. I certainly can recommend that to the staff to study.

Senator ROCKEFELLER. Let me just follow up on that for a moment. Dave and I both do a lot of town meetings and mine recently have been dominated by seniors with the catastrophic on their mind. I always go well prepared with the charts, not only the financial charts showing income levels and when supplemental premiums kick in, but also with what the benefits are. The benefits are incredible.

Mr. DELAY. That is right.

Senator ROCKEFELLER. I mean, they are absolutely incredible. And when you think that in my State 63 percent, at most—at least, I should say, of seniors will be paying only the $4 per month. Now, granted, anytime something is deducted without choice from Social Security there is an outcry from people who ask "why not choice, why not choice." If catastrophic were optional, though 80 percent of the people would not choose to participate and there would be no kitty from which to do the good work.

I have found two things. One, that when one has the time to explain it at length that people's concerns are allayed. And secondly, in that one usually does not have a chance to explain something at length, that nervousness is out there. I agree with Senator Durenberger that if this things gets opened up, who knows what will happen.

I did not vote with Senator Durenberger, but I share his views. I share his views. My seniors are upset. I am not sure they have reason to be upset. Now those seniors who are well-to-do—there are not that many of them in West Virginia that are making $50,000 or more, or couples making $75,000 or more, then they are going to look at those supplemental premiums and not be too happy. But then, I am not going to worry too much about them because progressive taxation is the way this country that we finance our programs equitably.

Another point, a couple of people told me that they had heard that AARP was going to back off of its position—some of our seniors. I was speaking to some medical group the other day and I saw one of the world's great people—Tricia Smith—and embarrassed her because this was a meeting of doctors and I said, now Tricia, you are not going to back out of catastrophic, are you? And she sort of left the room. I mean, it was friendly I am joking. But I would like to see that kind of an article myself that Senator Durenberger referred to.

Mr. DELAY. Yes. The AARP Board of Directors, as you may know, has just made a statement relative to its current position on catastrophic care. May I read just a very brief statement?

Senator ROCKEFELLER. Of course.

Mr. DELAY. "The AARP Board has heard, and shares, with concern the concerns of members about the rising cost of healthcare, particularly with respect to the method of payment for the Medicare catastrophic health program. We continue to support the important benefits provided by this law and, therefore, oppose repeal or delay on its implementation. AARP did not propose the acts financing method and does not believe it is the best approach.

"We remain open to new proposals for funding catastrophic program and will evaluate them in light of their equity and potential for support. We remain committed to broad-based sources of financing for healthcare costs, along with stronger cost containment and quality assurance measures. We believe the best of AARP's energies for the future continues to lie in advocacy for universal access to quality, affordable healthcare for all Americans for both acute and long term services."

Senator ROCKEFELLER. Thank you.

May I ask one additional question? In talking with various physician groups—both specialty and general medicine—when one asks why we have 15 percent inflation per year in Part B, part of the answer that comes back is technology. But a lot of physicians stress medical liability insurance and therefore the instinct for defensive procedures. Now one could look at that in two ways and I am asking how you look at it.

One could say, that is fairly understandable because if you think that you may get sued and this is a litigious country—and, in fact, I am going to charge right into the middle of the product liability debate, because I think in some ways America is losing its willingness to plunge into new areas. It has lost some of its nerve. But then on the other hand, there is a human dimension to that too—mistakes are painful.

Now, doctors will be more cautious; but doctors also are doctors and they are trained to know what precautions are necessary, and what precautionary procedures are necessary—what tasks, how many. Where do you see the balance, one way or the other, between the technology issue and the medical liability insurance issue?

Mr. **Delay**. We are concerned about the doctors problem or the cost of insurance. We are hopeful that over a period of time there can be some resolution of that problem into diminishing the doctor's care. As you say, I am sure that there is a defensive reaction to it. Even allowing for the cost of the insurance, providers are able to earn a very substantial income and we hope that they will not be so defensive that they will keep continuing to raise their costs using that as a basis.

Senator **Rockefeller**. I am not sure I understand the answer. Do you see the doctors overprotecting themselves—I am going to try to feed you one side—that is, they do not want to get sued so they take many tests although some of those tests may not reveal anything necessarily medically important, but perhaps legally important. Do you see them leaning too much that way, more than they need to as doctors?

Mr. **Delay**. I would guess that there is—I know that my own physician is quite indignant over that charge. He says he does not ask for tests that are not necessary. I have talked with physicians. I had the opportunity of being part of the American Medical Association Healthcare for America Committee and talked to physicians. There is some defensiveness and there probably is in overall affects some result in increase in volume and increase in fees, and increase in the fees coming from charges for tests and things of that type.

The hope is that as we develop this program we are talking about that there will be less of a consciousness of a necessity for that.

Senator **Rockefeller**. Thank you very much, Mr. Delay. I appreciate your testimony and you are always welcome back here.

Mr. **Delay**. I appreciate the opportunity.

Senator **Rockefeller**. Our next panel consists of Alan R. Nelson, M.D., president-elect of the American Medical Association from Salt Lake City, UT; Dr. George W. Weinstein, professor; and Jane McDermott Shote, chairman, West Virginia University, testifying on behalf of the American College of Surgeons; and, Joseph F. Boyle, M.D., executive vice president, American Society of Internal Medicine.

I called out three people and got five. Dr. Nelson, we will start with you, sir.

STATEMENT OF ALAN R. NELSON, M.D., PRESIDENT-ELECT, AMERICAN MEDICAL ASSOCIATION, SALT LAKE CITY, UT, ACCOMPANIED BY JANET HORAN, DIVISION OF LEGISLATIVE ACTIVITIES

Dr. **Nelson**. Thank you, Mr. Chairman.

I am Alan Nelson. I am an internist in Salt Lake City. With me is Janet Horan from the AMA Division of Legislative Activities, which explains partly why you have five instead of three.

In the brief time that I have, Mr. Chairman, I think that I will rely on the committee to examine in detail our prepared statement and I will talk informally about three areas—indemnity payment schedule, expenditure targets and Medicare assignment. As you know, of course, we support the refinement, expansion and appropriate revision of the Harvard RBRVS to constitute a schedule of payments for physician fees in an indemnity system.

We also oppose expenditure targets primarily because they would provide rationing of healthcare in this country. Our experience with our neighbor to the north is pointing out that that is not a good thing and would not be a good thing for the American public. For example, the wait in Vancouver for psychiatric neurosurgical routine orthopedic consultation is one to 3 months; 2 to 4 years for corneal transplantation. In all of Canada there are only 11 hospitals that are capable of performing open heart surgery; only 12 hospitals that have MRI equipment, in sharp contrast to the ready availability of specialist services even in small cities and towns in this country.

As a matter of fact, as we get into the discussion of volume—and I suspect that you will want to—I would have to identify one of the factors in increasing the volume of services, the easy availability of service that has provided specialized services in small cities and towns in this country so that patients who formerly went without surgical procedures—hip transplantation, cataract extraction, prostate surgery—now are taking advantage of the ready availability of those services near their home where their family can be with them. That is one of the factors undoubtedly increasing volumes.

One of the problems with expenditure targets that concerns me is the potential for conflict of interest that that would provide. While members of the medical profession are dedicated to their patients' welfare, they are also human and I have some concern about the potential for conflict of interest if a reimbursement schedule in a subsequent year is linked to the total volume of services provided in the proceeding year.

Of course, we support the PPRC's recommendation of increased funding for research and the quality of medical care outcomes assessment. We understand the need to have better developed criteria and guidelines for physicians to use. The AMA calls these perimeters to enable us to better understand what is necessary and how to provide care that leads to the desired outcome in the most efficient fashion.

The final point that I wish to touch on is that of Medicare assignment. It is apparent that voluntary assignment is working in this country—81 percent of charges in 1987 were assigned, 91 percent of physicians accept assignment for at least some patients, and 34 States have voluntary assignment programs either underway or in stages of development.

The PPRC's study said that 82 percent of beneficiaries had balance bills of $50 or less in 1987. So the voluntary assignment program is working and, of course, the American Medical Association continues to encourage physicians to take into account the economic position of their patients and to provide care that is needed at reduced fees or at no fees for those who require that consideration, and to accept assignment for those patients who should properly have so.

It is an equity issue. Those who are able to easily afford to pay the usual fee of a physician should do so.In this country we have hundreds of thousands of millionaires who were eligible for Medicare payments and the single category of patients in this country who are having the biggest difficulty in paying their medical bills may be those young working families that have less discretionary income.

The American Medical Association has a plan that would stop some of that intergenerational transfer of debt that we need to do.

I find it curious that at the time when we are talking about converting our system to a national health service, that the United Kingdom is talking about privatizing theirs—and both for the same reason, to contain costs.

Thank you.

[The prepared statement of Dr. Nelson appears in the appendix.]

Senator **Rockefeller**. Dr. Weinstein.

STATEMENT OF GEORGE W. WEINSTEIN, M.D., FACS, PROFESSOR, WEST VIRGINIA UNIVERSITY, TESTIFYING ON BEHALF OF THE AMERICAN COLLEGE OF SURGEONS, MORGANTOWN, WV, ACCOMPANIED BY PAUL A. EBERT, M.D., DIRECTOR OF FACS

Dr. **Weinstein**. Mr. Chairman, the American College of Surgeons appreciates the opportunity to testify before you today. I am Dr. George Weinstein and with me is Dr. Paul Ebert. We are here as representatives of the fellowship of the college.

In brief, the college's proposal consists of the following four complimentary elements: (1) a plan to moderate the growth in Medicare expenditures for surgical services by addressing the issue of volume and to make those expenditures more predictable for beneficiaries and the government; (2) a set of proposals for improving the financial protection of Medicare patients through changes in the assignment program; (3) the development of a blended Medicare fee schedule for surgical services that reflects both improved measures of supply side or resource cost inputs and important demand side considerations; and (4) a timetable for phased implementation of the proposed changes.

At the heart of our plan is a public commitment from the American College of Surgeons to reach an agreement on a broad range of physician payment goals that can be implemented in an orderly manner.

Mr. Chairman, as you may be aware, the College testified recently before the other body. On that occasion, Dr. Philip Lee, chairman of the PPRC, also testified. Based upon that testimony, we were pleased to learn that some of the concepts that were proposed by the college are likely to be included in the recommendations made by the PPRC as well.

If serious steps are to be taken to moderate spending for physician services under Medicare, then some workable approach must be found to strike a better balance among fee considerations, increases in volume and intensity and the financial protections afforded beneficiaries under the program. This, it seems to us, is far more important than focusing attention almost exclusively on how payments should be distributed among different categories of physicians.

We believe that physician-developed standards and guidelines are needed to make reasonable judgments about the frequency, volume and effectiveness of both procedural and nonprocedural physician activities. Ultimately, if guidelines are to influence the volume of services, it will be necessary to directly link payment policies with criteria that have been developed by the profession concerning the appropriateness and effectiveness of medical and surgical treatments.

In most major hospitals the responsibility for quality assurance and volume issues is assigned to specific medical departments with the experience and competence to deal with these issues in terms of defined categories of services. This is one reason that we propose to address the issue of increased volume of services exclusively within the scope of surgery and we are prepared to develop criteria to determine the appropriateness of surgical care.

Another reason for recommending the separate treatment of surgery is that tools are more readily available for addressing volume concerns relating to surgical services because many services relating to a surgical procedure are already bundled under and paid for under a global fee arrangement.

With the help of the surgical community, the PPRC has been working to standardize further the contents of the surgical bundle. And, for example, the Commission has recommended the inclusion of post-operative visit services occurring within 90 days of the operation. This bundling of surgical services stands in stark contrast with the current itemization of diagnostic procedures, tests and nonsurgical visit services.

Finally, under the College's plan, failure to meet surgery specific expenditure targets would result in future adjustments in Medicare payment levels for surgery services necessary to moderate aggregate spending for these services, without affecting the setting of payment levels for nonsurgical services. Similarly, volume increases considered excessive but found to be unrelated to surgical services would not lead to the application of expenditure controls on surgery. We believe that such a surgery specific accountability is both appropriate and workable.

We would also suggest that the Secretary of Health and Human Services calculate actual program expenditures for surgical services in a base year in order to determine on a budget neutral basis a surgery specific conversion factor. The factor would be applicable to Medicare surgical services, using a new blended fee schedule to be described later in this testimony.

For 1991 and each year thereafter, the conversion factor would be increased to reflect changes in the costs of surgical practice, including professional liability costs and changes in the general earning levels of other comparable professionals. The Secretary would be required to determine a national expenditure target for surgical services subject to a blended surgical fee schedule.

In estimating this expenditure target, the Secretary would be required to take into account Medicare population changes, cost changes and estimated changes in the expected demand for, and volume of surgical services that are required by Medicare patients.

In conclusion, Mr. Chairman, we have presented the elements of a comprehensive plan and fully intend to develop our proposals in greater detail. The College wishes to continue to provide constructive input and we look forward to working with the committee in addressing concerns about physician payment under Medicare.

Thank you for the opportunity to present this material. Dr. Ebert and I would be happy to answer any questions that you might have.

Senator ROCKEFELLER. Thank you, Dr. Weinstein.

[The prepared statement of Dr. Weinstein appears in the appendix.]

Senator ROCKEFELLER. Dr. Boyle.

STATEMENT OF JOSEPH F. BOYLE, M.D., EXECUTIVE VICE PRESIDENT, AMERICAN SOCIETY OF INTERNAL MEDICINE, WASHINGTON, DC

Dr. BOYLE. Thank you, Mr. Chairman and Senator Durenberger. I am Joseph Boyle, executive vice president of the American Society of Internal Medicine.

ASIM believes that an affective payment plan for physician payment reform should consist of implementation of a fee schedule based upon a resource-based relative value scale. ASIM specifically supports the PPRC's recommendation to enact legislation this year to mandate a Medicare fee schedule for all physician services regardless of specialty based on an RBRVS being completed by Harvard University.

We agree that partial implementation should take place within 6 months of enactment and full implementation over 2 years. Second, the establishment of a safety net to protect low-income beneficiaries from out-of-pocket expense they cannot afford. Although ASIM believes that beneficiaries are best served by a policy that enables them to contract with physicians who may bring to their care more experience, training or expertise than the norm and who, therefore, may charge an appropriately higher fee than that allowed by a fee schedule is appropriate to provide special protection for low-income beneficiaries.

Consequently, ASIM supports appropriate limits on balance billing to low-income beneficiaries. The PPRC proposal to require acceptance of assignment for all individuals whose Medicare cost-sharing must by law be paid by the respective States is consistent with this principal.

Third, expansion of policies designed to develop the scientific knowledge and the means to assure that only affective services are reimbursed by the Medicare program. ASIM has previously provided Congress with 14 specific recommendations on the volume issue. The recommendations include: increasing medical review of services provided in organized outpatient settings; substantially increasing the resources devoted towards the development of practice guidelines, particularly for high-volume services; studying ways to bundle certain physician services; increasing data collection and analysis; and instituting measures to improve the effectiveness of medical review.

We urge Congress, however, to proceed cautiously before mandating measures that could diminish access and quality of care such as the PPRC's recommendation for national expenditure targets.

Fourth, enactment of interim measures for fiscal year 1990 that are consistent with the long-term reform based on RBRVS. Capping prevailing charges for radiological, anesthesia and surgical services after adjustment for practice costs at some percentile above the national mean—for example, 120th percent—and increasing the existing floor now set at the 50th percentile of the national mean for primary care services could achieve fiscal year 1990 savings in a way that is consistent with long-term reform based upon the RBRVS.

It would also be far more fair than across the board cuts in these services provided in the President's budget. ASIM believes that this comprehensive approach to payment reform will have a favorable impact on several objectives that should be driving long-term reform. By substantially improving payment for undervalued primary care services patient reform with an RBRVS fee schedule at its core will correct distortions that now exist as a barrier to provision of these services in under privileged areas. Physicians no longer will be discouraged by the payment system from entering into primary care specialty or practicing in rural areas.

The PPRC projects that the physician services in rural areas, particularly primary care services would gain the most under this proposal. ASIM's proposal for a cap on prevailing charges for RAS services and raising the floor for primary care would similarly represent an important interim approach to expanding access in rural communities. An RBRVS fee schedule by neutralizing incentives that favor one type of care over another will also enhance quality. For the first time, physicians will not be biased by higher payment for the work involved for some services compared to others in making decisions on how best to treat their patients.

Since the amount of time a physician spends with patients correlates closely with the quality of care and patient satisfaction, the RBRVS no longer penalizes physicians for time consuming cognitive services will also enhance the overall quality of physician payment encounters. Establishing limits on balance billing to low-income beneficiaries will protect those who cannot afford to pay more than the Medicare approved amount under a fee schedule, while maintaining the basic right of beneficiaries to choose and contract with any physician of their choice.

An RBRVS based reform will also improve overall acceptance of the assignment rate. The impact on the budget of future increases in payment rates will be far more predictable under the current system. In addition, by neutralizing the incentives that may encourage excessive reliance on certain technological services, overall costs can be expected to moderate in the long run. Development of practice guidelines can also achieve future cost savings, particularly if developed first for those services that have experienced the greatest increases. Implementation of an RBRVS fee schedule, beginning in 1990, is at the core of this proposal and therefore merits immediate action and attention by this Congress.

ASIM stands ready to assist the subcommittee in any possible way in bringing this proposal to fruition.

Senator ROCKEFELLER. Thank you, Dr. Boyle, very much.

[The prepared statement of Dr. Boyle appears in the appendix.]

Senator **Rockefeller**. I thank all of you and we will begin our questioning with Senator Durenberger.

Senator **Durenberger**. Mr. Chairman, first just an editorial comment and that is to express our appreciation to physicians everywhere in this country to the long time commitment about doing something about CPR and changing to a relative value or some other kind of a reasonable prospectively priced system.

I just acknowledge one more time, I suppose, how often the physicians in America have been trying to tell everybody else that this was a much better way to go than the old system. And so even though there are slight differences in the testimony that comes with regard to the recommendations on a resource-based RVS, I think all of us should recognize the fact that we owe a debt of gratitude to the physician community for trying so long to alert us to the fact that we have not had a very sensible reimbursement system in this country.

Then I would like to move from that editorial comment to a related question. I am sure it is in the physician community that we have long recognized that a prevailing charge is not as Senator Hatch said in his statement necessarily reflective of actual practice costs. I would assume that all of you might make the argument that there needs to be some geographic differences in this country but that it has gotten out of hand. And I do not even have to ask Alan Nelson that question because he is from Utah and they are at the bottom; and yet, they do very good medicine in that State.

But one of the propositions that our colleague puts forward is this, that the actual cost of practice differences out there in America are not as much as current prevailing charges would indicate. He identifies these costs of practices as malpractice insurance, employee expense, office rent, supply and so forth. And yet we find this incredible disparity that seems to exist out there between the—I think it is something like 32 States that are below the national average and there are 10 that are above the national average. I always pick on Florida. I do not know why. I should not be doing that. I guess I should not be that specific.

But every time I do it in some kind of talk there is a physician from Florida who stands up and says, you're absolutely right, so I guess I keep saying it. But my biggest concern is between, say, just rural Florida and the big cities, for example. And so, I guess the first question of all of you is, is it possible for us to measure in some way the actual cost of practice out there and to factor that as a convertor, if you will, into the RBRVS and do you all take the position that that is something we should do—try to eliminate all of the unjustified cost of practice differences—recognizing that Florida has a whole lot of illegal immigrants, and Texas does, and New York does, and so forth—but to continue to buy those kinds of services with Medicare dollars would be to distort the system, just as one example.

Dr. **Nelson**. Yes, I think that it is possible to do. The PPRC recommended that that be factored as a separate factor from professional liability costs and I do not think we have any real problem with that.

I called our billing person before I came and asked them to tell me what my usual fees for an office call for an internist are. I had some idea, but since it is upgraded each year according to an increased cost of living factor, I was not exactly sure. Our usual fee for an office visit is $29. The MAC-approved amount—the Medicare-approved amount is $24—and Medicare pays $17. Now that is a substantial difference between what the young working person is paying and what Medicare reimburses me.

So in the context of geographic inequities and practice cost differences and whether they can be accommodated in a new schedule of payments, the other to me more important discrepancy is the difference between what Medicare and Medicaid pay and what the ordinary working patient pays.

So I am optimistic about the feasibility and workability of a resource-based RVS. I am optimistic about the extrapolation for evaluation and management services. It is something that we can deal with with practice costs. It is something we can deal with and what we come up with will be much more fair than what we have now, even if it is not perfect.

Senator DURENBERGER. As the others of you respond to that question, would you indicate whether or not you think there needs to be some phase-in of the elimination of geographic disparity.

Dr. BOYLE. First, Senator Durenberger, there is no question in our mind but that it is feasible to develop actual cost data for a practice. I think you need to keep in mind that there are differences in practice style. The policy that our society has adopted is that we believe that there ought to be a uniform payment for the same service across the country. The only variations ought to be for legitimate and identifiable variations in practice costs.

Now you think that this has to do only with rural practices but you need also be aware that this also affects intercity practice in many large communities. In the community where I practiced up until three and a half years ago, people who were in practice in Centinella Valley were paid at a rate of about half of that which was paid in Beverly Hills. Now Centinella Valley is not some place out in the weeds. Centinella Valley is right across the street from Beverly Hills so that there is a tremendous variation that cannot be justified in payment for service.

So far as phasing in changes in reimbursement are concerned, we believe that the Congress has gone a long ways towards beginning to correct some of these inequities without creating tremendous disruptions in practices, and we believe that the most expeditious way that one can go about doing it will probably in the long run produce the fewest disruptions. So that I think that it is not necessary to spend 4 or 5 or 6 years to get there. I think the PPRC's recommendations are reasonable and it can be started a year from now and can be completed in a matter of 2 years.

Dr. WEINSTEIN. Senator Durenberger, I would like to begin by commenting and then ask if my colleague, Dr. Ebert, may also add to my statements. But coming as I do from the State of West Virginia, Senator Rockefeller's State, I would like to point out that one of the reasons why the American College of Surgeons is proposing a blended relative value of scale system is that it really addresses in some ways this very issue. That is, it addresses the demand side of the reimbursement picture.

In a State like West Virginia or others such as the one represented by Senator Hatch, the fact is that we are not in a position to retain very well physicians that we already have. That means that access to care is threatened. Not only do we have the problem of retaining physicians, but it may be difficult for us to attract young physicians in the future. It is conceivable that a blended relative value scale system such as the one that the College has proposed would take into consideration the demand side. The fact is that patients in West Virginia need care too and that there needs to be some recognition for the compensation for this. Therefore, a geographic factor that may be phased in—the College is proposing something like a 3-year phase-in for geographic considerations—might very well then compensate for the fact that access to care—is being adversely affected—under our current system.

May I turn the floor over to my colleague, Dr. Ebert.

Dr. EBERT. I just want to add, Senator Durenberger, I think last year in this same room we pointed out a lot of the problems with geographic variation and services and we whole-heartedly support the concepts you put forth.

I think there is just one thing that is a little different from surgery and that is the bundling of the service. In much of the discrepancies that one often sees in the price that is paid for one's service, it is because the particular code in the particular bundle is totally different. In other words, in one area an operation may be charged what seems like a less amount but the pre- and post-operative care has been added as an a la carte expense on top of that but does not show up in the prevailing charge.

And up until recently, I think this year, I would have to ask our colleagues at HCFA, but I don't believe they yet can put together all the Part B costs of an individual stay within a hospital related to one person's service. We certainly agree that if the bundle can be identified and a loop put around what it is, then obviously the service is worth the same thing besides your practice costs any place in the country.

Senator DURENBERGER. Thank you, Mr. Chairman.

Senator ROCKEFELLER. Dr. Nelson—Well, let me start out also with an editorial as did Dave with respect to doctors. One of the reasons that I mentioned that I do not want to be talking about winners and losers—I do not want that to be the focus; that is not the point of this—is that doctors are under a lot of fire in general because they make more money than other folks. Of course, there are reasons for that in that you do things other folks do not do and you study far longer than others do in order to be able to do that.

America measures success, even value, by salary or by how much one makes. That is not necessarily fair, but that is the way we tend to value things in society, or measure things in society. So doctors come in for a lot of criticism. From my point of view, I want to say at the beginning of this process that I do not share that feeling.

I have lived in places more rural than I could have ever imagined that I would have lived when I was growing up—communities of 5,000 people where I have seen doctors who worked themselves each week into a state of absolute exhaustion. Sunday is their day of recovery, but only if there hasn't been an emergency somewhere in the county. A family practitioner may take a correspondence course, so to speak, and become a surgeon—if there's no other surgeon in that community. At the same time, the same doctor will be the county coroner. The doctor will be the person who stands on the sidelines with the high school football team and is very white most of the time from exhaustion, but keeps doing it.

I have the same view towards physicians. I have been a patient in a hospital and I have visited patients in hospitals and there is something about the experience and the competence and the incredible difficulty that is involved in specialization—neurosurgeons, I mean, you just take it wherever you want. It is an extraordinary service. We have the best in the world and I have to assume that we have the best doctors in the world.

So as I start out all of this process I want that clearly understood by all. There is going to have to be adjusting and that will either be well received or not well received. But the view of this particular Senator towards those who choose medicine as a career—whether they be general practitioners or specialists—is one of very heavy respect.

Dr. Nelson, if expenditure targets are implicit rationing as you have said, how would you then characterize our present system which allocates healthcare on the ability to pay?

Dr. NELSON. I do not know of hospitals in this country that are turning away patients who require care, even if that patient is indigent. We have been paying for it. It has been said that we are paying more than we should. It is easier to say that if one is healthy than if one is ill. And on a case-by-case basis, as a physician, it would be cynical of me to not provide for a patient what I would want for myself or my family.

If we have some expenditure target that puts in place a finite number of dollars and links that to a reimbursement payment system—to a payment system for physicians—and in a subsequent year through a conversion factor adjustment, that gives me a great deal of concern as I had said before.

There is no question that we have people in this country who do not have access to medical insurance, and should. There are a series of things that we can and must do to correct that. But I do not think that adding on to that obligation—adding on to the difficulty of providing necessary care, efficient care, getting rid of the waste which we accept, I do not think that compounding that with another undesirable factor is going to help in the first instance in finding ways of caring for the uncompensated care we provide.

Senator ROCKEFELLER. In your testimony you state that, "implementation of expenditure targets could lead to denial of care for Medicare beneficiaries." Why would this necessarily happen?

Dr. NELSON. Any system that seeks to control the prices for a certain segment of the population runs that risk. Let me give you a very brief example. Suppose that a law was passed that said that elderly people in D.C, could not be charged more than $10 for a meal in a restaurant. Can you visualize what would happen?

First, the volume of meals in restaurants consumed would go up. Secondly, as restaurants tried unsuccessfully to continue to provide a high quality meal for $10 the quality of meals would go down. And thirdly, some restaurants would say that they could no longer provide meals for elderly people.

Now that clearly is not the same as medical care. But I think that it is an economic model that at least deserves our consideration. As we attempt to cap expenditures for one segment of the population for an essential service like medical care and couple that with increased demand that comes from consumer desire for necessary services—such as routine mammogram screening, or colon/rectal cancer screening, or appropriate surgical services that people want and need because it makes us more production and enhances the quality of life—if we attempt to cap that with a system which one size piece of money is available, that is going to erode the quality of the care.

Senator ROCKEFELLER. As far as I know, the PPRC proposal calls for reducing fees, not covered services if expenditures grow too fast.

Dr. NELSON. As I understand expenditure targets, PPRC put that in place in an effort to control volume—volume of services—with some assumption that there is excess volume that should properly be constrained. There may well be unnecessary service and we need to find a way to identify that an eliminate it.

But if the question to increasing volume is to put a cap on it, which is what expenditure targets does, that is not the right way to go about it. Good studies into effectiveness of care and what necessary care is, the elements of outcomes research, that is the way to approach the control of volume.

Mr. Chairman, as long as we get on the television once a week and tell folks that they ought to have their cholesterol measured, we cannot be surprised if they come to me as a physician and ask for their cholesterol to be measured. Not only do they ask me what their cholesterol is, now they want to know what the HDL is and what the ratio is, and properly so.

As long as that enhances the productivity and quality of life for our people, it is an investment that we should make.

Senator ROCKEFELLER. I understand. Let me follow on it. In your judgment would doctors deny needed care if their fees are cut?

Dr. NELSON. I certainly hope that that does not happen. But I do not have—sooner or later the system has to take into account the fact that our costs are going up—our taxes are going up, our professional liability insurance is going up. If we identify one portion of the patient population and put a lid on that, eventually some physicians will say that, unfortunately, if they have to choose between two new patients and one of them is Medicare eligible and the other one is not, they may very well not choose the Medicare eligible if the payment for that is held out.

Senator ROCKEFELLER. Now we have cut fees on the Medicare in the past. Has that, in your judgment, led to a cut in care?

Dr. NELSON. In access to care?

Senator ROCKEFELLER. Yes.

Dr. NELSON. Yes.

Senator ROCKEFELLER. It has?

Dr. NELSON. Yes.

Senator ROCKEFELLER. Is there any way that you could show that to me, document that for me? Not now.

Dr. NELSON. Sure. I will make that available to you.

Senator ROCKEFELLER. Okay. Good.

What effect in your judgment would practice guidelines have on the effect of medicine?

Dr. NELSON. Well, first it will—you know, Mr. Chairman, I do not wake up in the morning and say, well, I think I will go out and increase volume today. And I certainly do not go out and say I think I will provide some unnecessary or low quality care today. What we as a profession need is more consensus on what appropriate care is, what value is, and the care we provide. We have been working at that now for some period of time. It is not easy to do. But I think we need to devote more resources to it -to forging a consensus on what the best way of solving a problem is and the educating physicians so that they will follow those perimeters. And the AMA, as you know, as entered an agreement in order to try and provide that.

So enhancing the quality of care through a clearer understanding of the best way of solving problems and taking care of particular illnesses. That, to me, is an extraordinarily important commitment.

Senator ROCKEFELLER. The PPRC's data indicates that more than one-third of physicians bills to elderly and poverty involve extra billing. You indicate in your testimony that low income Medicare beneficiaries are adequately protected from balance billing. Can you comment on this?

Dr. NELSON. Well I think the PPRC data also show that there is a higher rate of acceptance of assignment among the low income elderly, so that supports the willingness of physicians to take into account the economic status of their patients.

Senator ROCKEFELLER. Many of the physician specialty groups have indicated support for mandatory assignments for low income patients. Why does the AMA oppose such a policy?

Dr. NELSON. Well I sort of spoke to that in my earlier remarks. First, I think there are three essential reasons. The first is an equity response—that is that those who are able to afford the physician's usual fee should pay that usual fee. Secondly, I think we also have to look at some of the data that suggests that less out-of-pocket costs for those who are able to afford the usual fee may very well increase the volume of services delivered.

Recent Rand studies show that volume of services go up as a personal contribution to paying for the care goes down. That a continued investment of personal income for those who can afford it in their healthcare makes them more liable to be prudent purchasers.

Senator ROCKEFELLER. Generally speaking, I am not sure of my figures on this, about 30 percent of doctors in this country are general practitioners, family physicians, et cetera; and about 70 percent are in specialty areas. My understanding is that in most other countries the ratio is precisely the opposite. How does one explain that?

Dr. NELSON. I think it is important to understand that many specialists also do a lot of primary care, particularly among internal medicine specialists.

I am a board certified endocrinologist, but the majority of my patient care in my office is primary care services. So the designation of a specialist and identifying that with the precise services and procedures that the physician does, it may not be a clean distinction.

In foreign countries you are quite right, they have a larger percentage of primary care specialists, but they may perform—their specialists are hospital-based consultants who may not do the same kinds of primary care roles that our—I mean, surgeons do a fair amount of primary care, and OB/GYN's certainly do. So I think it is an artificial distinction in the definition of what a primary care practitioner is in this country. And it is a good way to be. Let me say, it is the best way to be in my view, because it would be inconceivable to me in my primary care—wearing a primary care hat—to put my patient in the hospital and not be able to continue to follow them and provide the continuity of care.

In that sense our system is unique and it provides that continuity that makes a better system, in my view.

Senator ROCKEFELLER. You testified that the ability to balance bill must be maintained as a reward for the most skilled physician. Does the AMA have data somewhere indicating that only the most skilled physicians extra bill?

Dr. NELSON. No, I don't think that that is right. But I think that as we talk about the imperfections of any schedule of payments for physicians, one has to understand that there should continue to be the option to balance bill—to straighten out first the imperfections and provide some rationality; and secondly, if I take more time with my patient, if I don't make them wait in my waiting room, if I provide more information for them about drug interactions, if I provide a higher quality product in the marketplace, then I should be able to bill that patient the difference, if they are willing to pay that for that service.

That is the way our system works. I think that is also an important ingredient in maintaining quality of care.

Senator ROCKEFELLER. You talked a little while ago about the Canadian system and you cited some of the negatives of the Canadian system, including waiting lists for surgery. I do not characterize the Canadian system. But I would have to assume that there are some positives associated with that system.

In Canada there is universal health insurance, universal access to healthcare, so far as I know. A much smaller percentage of Canada's GNP is required to provide this care and the result overall appears to be positive. The Canadians seem to approve of it. The infant mortality rate is much lower and so on. So should we not be trying to find something decent in what they do up there?

Dr. NELSON. My colleagues from Canada make no bones about the fact they don't necessarily think that their system would work well down on this side of the border. We are a different size country with different demographics. It is also curious to me that the people who are talking about adoption of the Canadian system in this country are not the Canadians who think that it is exportable, it is a certain number of folks down on this side of the border that think that that might be a way to save money.

I personally think that if we adopted a national health system in this country total costs would go up because demand would go up, because there would be less out-of-pocket. The only way that you could really control demand for care would be by rationing facility placement as they have done in Canada. I think the quality would go down because the care in this country would not have the same characteristics that the Canadians describe up there; and down here I do not think anyone would be willing to ration care. I hope not.

Senator **Rockefeller**. Would you oppose separate expenditure targets for medical and surgical services?

Dr. **Nelson**. Our position, as you know——

Senator **Rockefeller**. I know.

Dr. **Nelson** [continuing.] Has been opposing expenditure targets for both.

Senator **Rockefeller**. In general.

Dr. **Nelson**. Yes.

Senator **Rockefeller**. What is your position on separate targets for States or carrier regions?

Dr. **Nelson**. Expenditure targets are expenditure targets and we are opposed.

Senator **Rockefeller**. I cannot do anything with that one then. Are you concerned about the differential in fees that would result if a geographic multiplier—if one of those was used?

Dr. **Nelson**. I do not understanding your question.

Senator **Rockefeller**. Simply, are you concerned about the differential in fees that would result if a geographic multiplier was used?

Dr. **Nelson**. Yes. Obviously our position is in opposition to geographic differentials except as they can be rationalized through difference in practice costs.

Senator **Rockefeller**. Do you have any good data that measures the costs of a physician's practice?

Dr. **Nelson**. Yes. I am not so sure that it is useful in the implementation of an RBRVS because it is a sample that is nationally derived and I am not sure it is statistically valid for any separate geographic location. But we have numbers on physician practice costs and we can make that available to you.

Senator **Rockefeller**. Dr. Boyle, would you oppose separate expenditure targets for medical and surgical services?

Dr. **Boyle**. Senator, I think that however you go about reforming payment in this country it would be wisest to treat the profession as a whole. I do not believe that, as an internist, I could separate out the needs of my patient for medical services or surgical services. I do not believe that it would be a desirable position for the Congress to place itself for the future, to continue to have to be an arbitrator between two different segments of the profession coming and saying we need more here, no they do not need more there.

I think the experience that they have had in countries where they have tried this and treat it as different segments of the profession differently would illustrate quite clearly that that conflict not only does occur but it continues and it exacerbates differences between professional groups rather than helping to bring them together. It would appear to me far more rational to find some level playing field at which point then one ought to proceed with trying to treat the profession as a single unit.

I might also point out that in this process, it is highly desirable that we try and find some rational way of making certain that we are paying for all the appropriate care that is necessary; that if want to try and limit volume that you not simply approach this from the standpoint of saying, well we are going to put a cap on the total amount of money that we will pay and when you go over that, then we are going to penalize you, because there are so many variables currently unknown as to what constitutes an appropriate volume, that this in itself to us would be a counterproductive approach. At the time when we are trying to find out what this is all about to say we are now at this point simply going to limit that aggregate without the fundamental database that you need to make the decision in the first place would not seem to me the most judicious way to fly.

Senator ROCKEFELLER. Okay.

Senator Durenberger, you pitch in any time you want here.

To you also, Dr. Boyle, the American College of Physicians who will testify shortly support an overall limit on balance billing, such as 120 percent of the fee schedule charge. You do not support an overall limit. Why is your position different?

Dr. BOYLE. Well, we have different ways of arriving at policy statements to begin with and have different policy making bodies. However, so far as the American Society of Internal Medicine is concerned it is an extremely important precept that there is a contract between physician and patient and that at each point in which somebody interferes with the ability of two people to freely agree among themselves, and contract with one another, you interfere likewise further down the line in other aspects of that contract. This has to do with my committing myself to providing you with the care you'll need, you committing yourself to certain responsibilities in that process as well.

I think also, as Dr. Nelson has indicated, there are those occasions in which patients want, demand and receive more. But from the standpoint of codes and a fee schedule, they cannot be separated. It ought to be perfectly feasible for those patients to be allowed to enter into a contract for a larger fee.

Furthermore, I believe that it is extremely important that if you are going to allow for differences in competence—if there is some way in which somebody can hold themselves out as a more competent physician or providing something over and above that which other physicians do also—that that person ought to be able to say, "I am worth more; therefore, I want to charge you more." Then the market ought to be able to determine whether that patient is correct or not. If people will not pay that fee then perhaps they will not have made that point.

It would seem to me not logical to accept the premise that because you want to protect some smaller subset of the elderly people from abuses that perhaps can be handled in other ways, that one would say that we are going to mandate that nobody may enter into any kind of a contract such as that.

Senator ROCKEFELLER. A personal question. When you were studying to become a doctor, why did you decide to become an internist?

Dr. BOYLE. When I was in medical school I probably decided to be about seven different kinds of specialists before I got finished. In my internship it became apparent to me that I was probably closest to that part of medicine that was engaged in problem solving, in dealing directly with patients on a continuing basis. General practice in those days was not the same kind of a specialty that family medicine is today. Internal medicine was something that was to me a more challenging specialty and I decided that I would rather be a thinker than a cutter.

Senator **ROCKEFELLER**. That's delicate. [Laughter.]

Students in medical schools these days come to a decision as to what field they want to go into through a whole variety of motivations. In your judgment, how much of that is financial?

Dr. **BOYLE**. I think that it goes beyond what is purely monetary reward, Senator.

Senator **ROCKEFELLER**. I assume that. But I just——

Dr. **BOYLE**. No, I am going to get to that point. That is, people as you indicated tend to assign a value to something by what kind of dollars it brings. As a consequence, if you persist in telling a group of young people that this is worth more than its counterpart over here, they are going to start thinking, well maybe that is the way I ought to go. Not only that, but it pays better. So my experience in dealing with young people in medicine these days has been that they start out with the same kinds of motivations that I think everybody at this table did who is in the practice of medicine, that is you wanted to take care people. You were not thinking about how much money you were going to make or you are going to have a good living, a big house or any of those things. You started out because you wanted to go into medicine.

I think the medical students start out in the same place today. But as they go along, there is no question about the fact that there is now more and more incentive to people to choose procedurally oriented specialties because society apparently puts a greater value on them.

Senator **ROCKEFELLER**. Dr. Weinstein, most of your fellow physicians oppose expenditure targets because they feel that spending limits will lead to rationing of necessary care. What is your response to the that position?

Dr. **WEINSTEIN**. Senator, we believe that expenditure targets are really nothing more than the reality of budgetary constraints that all of us are faced with in our personal lives and in society in general. I believe that it really remains the responsibility of you, and your colleagues, and Congress to decide what society wishes to spend on medical care, on housing, on education, and so on and so forth.

We believe that it is reasonable to work within a budget and I think that budgets are realities. Expenditure targets are perhaps nothing more than just synonyms for that. We believe that we need to work within the realities of what this Nation can do. I do not believe that this Nation—maybe it is the most resource laden nation in the world—but I do not believe that any nation has unlimited resources.

Some tough decisions are going to be made. As physicians, we never want to make the decision whether to provide care or not to provide care. But as representatives of society, you and your colleagues may have to make some of those very difficult decisions for us.

Senator **Durenberger**. Mr. Chairman, could I ask a question?

Senator **Rockefeller**. Please.

Senator **Durenberger**. And I am only interjecting myself because—I have two reasons. One, because I have heard a lot of people say that it is our responsibility to do what you have just said, doctor; and also, because I wanted to ask you a question about something that is in a statement that we will not hear for a few minutes.

The difficulty with the expenditure caps is it is sort of like the difficulty in—at least for me in dealing with the Canadian kind of public utility medicine, that it does not really reward the really good folks for doing what they do best. It is not an encouragement for the best to become even better and for the other folks to find some other line of business.

So, my question—my concern—directed generally to all of you I suppose, too, is with an expenditure cap it is kind of difficult to determine who is doing the most effective medicine. The cap, in and of itself, is not going to assure you that only the things that need to get done get done by the folks that do them best. It just means that probably somehow or other you are going to put some caps on how much you pay for these sort of things. And so one of the things we struggle with is—I do, I cannot say we—that I struggle with in this whole notion of a cap is, who decides within the cap the issues of medical necessity and the appropriateness of a procedure and all that sort of thing.

Would you want to—either of you start by responding to that?

Dr. **Ebert**. I think you used the word cap. I do not think we have ever used that word, although I recognize they are closely aligned. Crippled children's programs in most States use caps. When they run out of money in March, April, May, then services are suspended or you're put on delay. I've worked with them for many years and it is a quiet time in April, May, and June usually in those settings.

What we are basically saying is that right now, as Dr. Weinstein implied, we have a budget, we have a reduction of it, and then an application of where Medicare is going to go that year. I wish in Dr. Boyle's comment that all were treated equal in this setting, but the last 2 years there has been overpriced procedures, some reductions. It is very unpredictable on a year-to-year basis as to where one goes.

Now there is no question if you crank down finances far enough as the Medicaid program has, then you have problems like you are hearing about in Oregon or in Virginia where certain priorities are going to have to be set as to what services will or will not be covered. Now the College believes that if you have a target within the scope of surgery—and there is no question that we have more developed guidelines, more control over people in hospitals and in ambulatory areas where surgery is performed—it is a better defined and regulated specialty already.

We say people want to go into specialty. There has been no increase in the number of individuals going into the surgical specialties in the last decade. We are one of the only groups with manpower growth that is way below what was projected for 1992. Now that has not been done by rationing; it has only been done, essentially, by maintaining quality within the training programs, and making the program criteria so restrictive that an individual was trained properly when he came out. That has maintained surgical manpower at a very flat level. There is no surgical specialty that has grown above where it was a decade ago. The college has kept records of every name of every resident in place.

So with respect to manpower, per se, it used to be that 17 percent of individuals in the medical school classes went into surgery. Medical school classes went up and now we are down to about 12 percent or 13 percent, because of the larger numbers. They have gone into other specialties. I agree that they are more procedure oriented. But to go to your answer, I think a target is a target and we are only willing to say that if we exceed it, then the conversion factor should be reduced. We have enough confidence to believe that in the rate of growth of procedures within surgery and operations, we do not really see a major increase. But we do not think the unpredictability of a current system is very valuable.

Senator **Durenberger**. The statement of the American Academy of Family Physicians says the following—and I will just quote and ask you to react.

"A recent examination of Medicare claims data"—and it does not say by whom— "for calendar years 1983 through 1986 demonstrates a very uneven pattern of growth in the volume of services. While the per beneficiary volume of primary care services, such as office visits, has increased little, if at all, volume has increased rapidly for surgical and diagnostic procedures. Three kinds of service grew at above average rates: surgery, radiology and specialized diagnostic tests, such as electrocardiograms, cardiac stress tests, and ecocardiography. Together, these three types of service account for two-thirds of the increased spending."

Dr. **Ebert**. I think that is a question there of how you define surgery. Dr. Weinstein could answer it probably very well in the cataract area. There are many surgical services that are down in that same list that Janet Mitchell put in. General surgery is down 29 percent; cataracts up the most and I think there is a logical reason for that.

Dr. **Weinstein**. If I may address the issue of cataract surgery, since that happens to be my field. About a decade ago we had really reached a fairly level number of cataract procedures, around 300,000 procedures, per year, in this country. That changed dramatically when cataract surgery improved and then when the lens implant was introduced into surgical practice. The number has reached the level of around 1.2 million cataract surgeries per year.

The reason for this is simply that cataract surgery is better. People see a lot better from cataract surgery than they ever did before. A new level has been reached which most likely will begin to decline. In other words, I believe that it is fair to say that the amount of cataract surgery done annually has essentially become saturated and may, in fact, drop off somewhat in coming years. But I think there is an example of a medical procedure, in this case a surgical procedure, done by eye cutters who I hope are thinking while they are cutting, and a procedure which provides benefit to patients in a way that makes them very much happier than before they had the surgery. They can see to read, to drive, to take care of their households, to go back to work.

As a result of that, we have seen an enormous increase in the volume of surgery.

Senator DURENBERGER. Is the answer then that, in this period of time, 1983 to 1986, that most of the increase in surgery is due to the fact that we can now do cataract surgery? Is that the answer?

Dr. WEINSTEIN. I was just going to say that is one example. But certainly, total hip replacement. There are certainly other kinds of procedures that provide benefit to patients. And if those benefits are obvious and available, then people will wish to take advantage of them.

Senator DURENBERGER. And then radiology, why is there a big increase in radiology?

Dr. EBERT. Well, I am not a radiologist, but I would say that in the one area where it has increased considerably—coronary bypass surgery—it is because balloon angioplasty came along as an alternate treatment methodology. Coronary bypass operations have now decreased somewhat per year to a rather flat plane whereas the angioplasty procedures have gone up rather high in frequency. They would either be done by cardiologists or radiologists.

But they are listed as a procedure. Our scope of surgery would not include those. They are not inclusive because they are not done by surgeons.

Senator DURENBERGER. Go ahead.

Senator ROCKEFELLER. Okay. Another question, Dr. Weinstein, is it your position that the special expenditure target for surgery be set so that Medicare spends the same amount for surgical services?

Dr. WEINSTEIN. I am sorry, I do not understand. The same amount as this year?

Senator ROCKEFELLER. Yes.

Dr. EBERT. It was written into the concept, Senator. It was not an attempt to reduce spending but to reduce the rate of spending. We proposed it as a budget neutral position.

Senator ROCKEFELLER. All right. Now if we do that, how do you recommend that we increase payments for primary care which has been underreimbursed in the past?

Dr. EBERT. Well, I think that if you look at the total cost of expenditures for Medicare item-by-item and then look at surgical charges, they are not exorbitant. The prevailing fees that are paid certainly are not similar to what private insurers are paying. We recognize that if you held surgery to a specific level, so to speak, that other services may have an increased rate of growth, and the program would adjust over a period of time.

We do not agree with our colleagues that a redistribution, so to speak, out of surgical dollars is the answer to the primary care. Last year we testified that more money should be put into primary care visits. I think that there is little question that this is still correct.

Senator ROCKEFELLER. What if the research in medical appropriateness shows, as some studies appear to be showing, that many services are unnecessary? If there is unnecessary surgery, shouldn't a surgical expenditure budget be adjusted to reflect that?

Dr. **Weinstein**. I would say that the profession is quite prepared to determine what is necessary and unnecessary. I think that when it comes to practice standards, this is something that is characteristically done already. Every hospital in the Nation has medical staff privileges that have to be defined and service-by-service, that is department-by-department, internists have to look at their colleagues in internal medicine, pediatricians, surgeons at surgery, and determine whether care is appropriate or not.

I think that you ought to be able to count upon the medical profession to provide the assurance that unnecessary care, of whatever kind, is not reimbursed.

Senator **Rockefeller**. One final question for Dr. Nelson. The AMA opposes MAACS and limits on balance billing. Aren't you testifying that doctors should be allowed to charge whatever they like? If so, why bother creating a fee schedule?

Dr. **Nelson**. No, not at all. Certainly I am saying that one segment of the economy should not be singled out for unfair price controls. I talked earlier to the disadvantages of capping one segment of the economy. But the schedule of payments in a fee-for-service system should be rational and appropriate and based on some logic and the RBRVS holds promise for meeting all of those criteria. So that, unless we are all on a salary, there would clearly be the need for some reasonable basis of providing payment for services. That is what the RBRVS does.

Senator **Rockefeller**. Okay. I appreciate all of your being here. I hope that I have not caused anybody, not only in this panel but the next panel, to miss a plane. Your testimony is important and we are grateful to all of you. Have a safe trip back to West Virgnia.

The next panel is Dr. Robert Graham, executive vice president of the American Academy of Family Physicians, of Kansas City, MO; Dr. Edwin P. Maynard, president of the American College of Physicians, Boston, Massachusetts; and Jacek B. Franaszek, President of the American College of Emergency Physicians, from Hinsdale, Illinois.

We will start with you, Dr. Franaszek.

STATEMENT OF JACEK B. FRANASZEK, M.D., PRESIDENT, AMERICAN COLLEGE OF EMERGENCY PHYSICIANS, HINSDALE, IL, ACCOMPANIED BY THOMAS NICKELS, DIRECTOR OF WASHINGTON OFFICE

Dr. **Franaszek**. Thank you.

You have to have a little Polish in you to say the name properly, I think. It is Jacek Franaszek, and I am a practicing emergency physician in Hinsdale, IL, which is a suburb of Chicago, and I am president of the American College of Emergency Physicians. I am appearing today on behalf of the almost 13,000 members of the college. To my left is Thomas Nickels, director of our Washington office.

We appreciate this opportunity to comment on various aspects of the upcoming report to Congress from the PPRC. Emergency medicine was not included in the first phase of the Harvard RBRVS study. However, we are now being examined in its second phase. The Harvard project represents a major contribution of the development of an RVS for physician services, one that more accurately reflects the actual inputs needed to produce those services.

The PPRC has proposed some important modifications to the Harvard methodology that we feel may make it feasible to use an RBRVS approach. In recent years, legislative changes have been enacted to redress some of the current payment imbalances for primary care services, including emergency department visit services. The issue of special recognition for primary care services arises because more time will be needed before a new payment system based on resource costs can be implemented.

We hope this subcommittee will continue to recommend differential treatment for primary care services, including emergency department visits, in connection with any payment actions taken by Congress on an interim basis.

We have some concerns, Mr. Chairman, about the PPRC's recommendation to move rapidly and implement a Medicare fee schedule in 1990. There is still much more to be learned before major revisions in payment rules are adopted. The impact on both beneficiaries and physicians of some of the proposed changes is not very clear at this time, but could be significant. Our own participation in the Harvard study, for example, is only just beginning and more time may be needed to develop the data needed before a workable fee schedule can be adopted. We urge that Congress keep these considerations in mind when deciding the appropriate time to initiate further physician payment reforms.

ACEP agrees with the PPRC that there are serious problems with the use of their current codes in defining physician work, particularly some of the codes for emergency department visits. The Commission is recommending that the coding system be revised so that time would be used as a significant factor in establishing different levels of service. There is a unique difficulty with linking the valuation of emergency services to time. Many emergency services need to be provided quickly. In fact, their value to patients is proportional to the rapidity of the intervention and not the length of the procedure.

Thus, ACEP believes that the value of emergency services should be more closely linked to such factors as knowledge, skill, effort and stress and not disproportionately to time.

Mr. Chairman, one of the major recommendations from the PPRC calls for a national target expenditure plan. The College opposes this recommendation in its current form, primarily because it fails to recognize the nature of the demand for emergency services by the Medicare population. Emergency physicians do not determine, nor control, the number of patients who come to emergency departments. In fact, many patients come to us who have nowhere else to turn.

Moreover, the College strongly opposes any steps that would discourage patients from seeking medical care when they are acutely ill or believe they need urgent medical attention. And, in fact, this is exactly why beneficiaries use our services. However, if Congress decides to adopt an expenditure target plan, emergency services should be and must be specifically excluded from that plan.

Finally, Mr. Chairman, I would like to share our views about the need for improvements in Medicare's assignment procedures. Based on our detailed study of Medicare data on emergency department visit codes, emergency physicians appear to have the highest assignment rates of all physicians, excepting assignment on approximately 90 to 91 percent of all claims.

We understand that the Commission has, in principal, endorsed the need for making changes in Medicare's assignment policy where beneficiaries have no meaningful choice of provider. Since patients who present with emergencies have no meaningful choice of provider and since the emergency physicians who treat them have no choice in the selection of the patients whom they treat, we agree that Medicare's current assignment rules should be changed under a new Medicare fee schedule.

If as part of this reform process payments for emergency physician services are reasonably valued, the American College of Emergency Physicians is enthusiastically prepared to support the acceptance of such payment levels as payment in full, thereby relieving all Medicare patients of balance billing obligations.

I wish to thank you, Mr. Chairman, for this opportunity to testify on behalf of emergency medicine and the American College of Emergency Physicians.

Senator ROCKEFELLER. I thank you very much.

[The prepared statement of Dr. Franaszek appears in the appendix.]

Senator ROCKEFELLER. Dr. Graham.

STATEMENT OF ROBERT GRAHAM, M.D., EXECUTIVE VICE PRESIDENT, AMERICAN ACADEMY OF FAMILY PHYSICIANS, KANSAS CITY, MO

Dr. GRAHAM. Thank you, Mr. Chairman.

I am Dr. Robert Graham, the executive vice president of the American Academy of Family Physicians. I am pleased to have an opportunity to appear before you and the committee this afternoon to give an overview of our comments. Since you have the full statement before you, I will simply try to summarize what I think are some of the more salient points and some of the points which you have already covered in previous testimony and your questioning of those witnesses.

We believe that the recommendations put before the committee by Dr. Lee and the Physician Payment Review Committee provide a historic opportunity to rebase the rules of physician compensation under the Medicare program and that this rebasing is not only in the interest of the majority of physicians involved, but very much to the interest of their patients and the beneficiaries of the program.

We recognize that there is controversy in this area. Our recommendation to the committee, though, is that as you listen to the points of view that will come before you, and as you take cognizance of the controversy, you continue to recognize that this is still an issue where timely action is necessary and demanded. This is not an issue where continued study or slow progress is necessarily in the public interest.

Let me highlight three areas that I think are most important for the committee's consideration as to why these recommendations are important. First, the focus has been on physician reimbursement. That is a very appropriate focus because that has to do with the methodology of Dr. Tsaio's study and the essential parts of the recommendations that have been made to you by PPRC.

However, there are many other implications about health services and access to services which flow from the recommendations regarding physician payment reform. It is not just how doctors will be paid or who may be paid differently, or better, or worse. It is how such payment governs behavior, the incentive system which is set up within the medical profession, the ability of physicians to practice the type of medicine they may not be able to practice now and, indeed, their ability to practice in areas where they cannot practice now.

We believe that the recommendations from the PPRC are important in a broad scope of public policy more than simply rebasing the way physicians are paid. That is a very important element, but there are other elements with which we are concerned and with which I believe the committee is concerned, that are also affected by those recommendations.

You have heard testimony thus far about some of the methodologic issues and some of the other policy issues within the PPRC. I will not try to go into detail with our position on each of those again because those are in the statement that we have already submitted to you. One thing that we do feel very strongly about was touched on by Senator Hatch at the opening of the hearing, and that is the opportunity through the response to the PPRC recommendations to treat more fairly physicians who choose to practice and deliver services in rural areas. We believe that the proper public policy base is to pay equal fee for equal service where that service is delivered.

Senator **Rockefeller**. You mean regardless of what kind of medicine that doctor is practicing? It's the ruralness——

Dr. **Graham**. The way our fees are based should be on services delivered, not the specialty of the doctor, not the geographic area. That is what we think, under a PPRC recommendation fee schedule, should be the basis of reimbursement. We are aware that there is conflicting data as to whether or not there are cost of practice differentials in rural and urban areas. We believe that the data suggests that there may well be some higher cost for physicians choosing to practice in rural areas which have not been taken into account by some other studies. Indeed, we understand that Dr. Lee has commented this week that the PPRC is willing to relook at some of their computations in this area.

Senator **Rockefeller**. Could you give your view on that matter and enumerate some examples?

Dr. **Graham**. Specifically, Mr. Chairman, there is perhaps an assumption that if you practice in an urban area, it is more expensive because everything is more expensive in urban areas—your rent is more expensive, your groceries are more expensive, your mortgage is more expensive. Those things may well be on an item-by-item basis be more expensive. But what people forget is, if you practice in a rural area and you use three different hospitals and those hospitals are 40 miles apart from one another, it is different than practicing in an urban area and using three hospitals and they're 5 miles apart. There is extra mileage, there is extra fuel, there is extra wear and tear, overhead.

If you practice in an rural area and you want to recruit a particular type of individual and there is only one such individual in the county or in the three-county area, that is different than having a pool of five such individuals in an urban area where there may be some market competition which sets the price of their compensation. If you practice in a rural area, you may feel that there are certain types of equipment that you want to have in your family physician or general internist or general pediatrician's office that if you were practicing in an urban area, you would not put that capital expense in because there is another one right around the corner or right down the street or in the hospital next door. You are not going to spend that extra capital.

If you practice in a rural area and you are 35 minutes away from the next source of more complicated care, you may not feel that you have any choice but to say that equipment.

So those are some examples of why we feel that looking very carefully at alleged cost variations in rural and urban differentials are central to our argument that the way you ought to start off on a new fee base system is equal pay for equal service.

Dr. GRAHAM. Since that colloquy has run us a little past time, I will summarize.

We believe the most important message that we can leave with the committee is that the PPRC study is well done, Dr. Tsaio's work is well done. It is controversial; it is complicated. Nobody welcomes change. However, in this case, we believe the change is in the broadest interest of the beneficiaries and the physicians who participate in the Medicare program. We would urge the committee serious consideration of the recommendations and expeditious action.

Senator ROCKEFELLER. Thank you, Dr. Graham.

[The prepared statement of Dr. Graham appears in the appendix.]

Senator ROCKEFELLER. Dr. Maynard.

STATEMENT OF EDWIN P. MAYNARD, M.D., FACP, PRESIDENT, AMERICAN COLLEGE OF PHYSICIANS, BOSTON, MA, ACCOMPANIED BY DEBORAH PROUT, DIRECTOR OF WASHINGTON OFFICE

Dr. MAYNARD. Thank you, Mr. Chairman.

The American College of Physicians appreciates this opportunity to present its views and the views of physicians in internal medicine and the subspecialties on the RBRVS. I am Dr. Edwin Maynard, president of the college, and an internist in practice at the Massachusetts General Hospital. With me today is Ms. Deborah Prout, the director of public policy at our Washington office.

The research conducted at Harvard and the work of the PPRC provide the opportunity and the means for Congress to replace the current Medicare payment rules with the system based on the relative value of physician's work. For the first time, we have an objective measure of the resource costs of medical services. After intensive scrutiny, no one has found major flaws in the core of the Harvard work for the development of an objectively measured scale of relative values.

With the Harvard and PPRC results there no longer can be any doubt that Medicare payments under the CPR rules have been based on factors other than the work involved and that rules favor high technology medicine over evaluation and management services. Payment reform is necessary to develop a rational, equitable system that corrects the failures of CPR. We urge you to enact legislation this year to incorporate the RBRVS into a Medicare fee schedule.

We have heard it said that the RBRVS is simply a means of redistributing Medicare revenues amongst different types of physicians, so why should Congress be interested in carving up the same pie in a different way? We think you should reject this line of argument.

Perhaps the most important message I can leave with you today is that the RBRVS has profound implications for patient care. It may also have important implications for the size of that pie. The RBRVS eliminates incentives which lead to medical decisions influenced by factors other than the necessity and appropriateness of the service. This is the right environment for providing optimal care for patients. It may also help relieve the upward pressure on the volume of services, particularly the procedural services. Time with patients, prudent management, appropriate services, simplified payments and access to primary care—for all these reasons, we believe that the RBRVS is good for patients and much more than simply a shifting around of Medicare dollars.

I would like to highlight three of our specific recommendations. First, the issue of geographic differentials. Without making the assumption that all rural costs are lower than urban costs, because rural physicians may have some unique expenses, we believe a fee schedule must carefully take into account real differences in the practice costs of physicians. Careful identification of regional cost differentials can help to ensure Dr. Hsiao's "level playing field."

Second, the issue of assignment. For reasons explained in our testimony, the College opposes across-the-board mandatory assignment. However, we believe that low income Medicare patients should be protected from balance bills. As part of a reformed payment system, we support a Federal assignment policy that is tied to income. While we do not have a specific recommendation on the income level which should be protected, a cutoff in the range of twice the poverty level would provide the protection of assignment for 35 percent of the Medicare population, a threshold of three times the poverty level would protect 54 percent of the elderly.

Additional protection for all beneficiaries could be provided as the PPRC suggests through a highly simplified maximum charge.

Finally, some comments on the proposed expenditure target. It is useful to recall the incentive of the DRG payments to hospitals. Beat this fixed price per case and you pocket the difference; exceed the fixed price and you eat the costs. The incentive works within a single hospital. The challenge is clear. The rewards and punishments are real and immediate and the tools within the control of the hospital administrator.

In stark contrast, the actions of an individual physician can have no visible impact on the achievement of the expenditure target. Any positive actions one individual takes may be negated by those of another person. The reward or punishment is vague and uncertain. The notion of meeting some arbitrary targets says nothing about ensuring the appropriate level of care. The cap may be set too high and allowed a large amount of inappropriate care that might be eliminated through other mechanisms or the target may be too low and jeopardize the provision of medical care for patients who need it. The target cannot assure that services are provided appropriately and it avoids the central questions of how much and what kinds of care this society should provide.

We have suggested as an alternative the use of practice guidelines. We believe the potential goes beyond the educational role discussed by the PPRC to a role in controlling the inappropriate utilization of services that would have more immediate impact on Medicare spending than the proposed expenditure target.

Evidence from at least two studies—one at a Boston hospital and another at UCLA—has shown that vigorous application of guidelines can produce substantial savings with no detriment to patient care. We suggest that the proper role for government is to use physician-developed guidelines and payment determinations. We believe there is enough agreement in certain clinical areas to develop guidelines for practice that are backed by strong utilization review and payment denial where appropriate.

In contrast to the expenditure target, this is real to the physician. It is controllable. If the physician performs an inappropriate service, he or she does not get paid.

We thank you, Mr. Chairman. We look forward to working with you to enact a rational and equitable Medicare reform using an RBRVS based fee schedule.

Senator ROCKEFELLER. Thank you very much, Dr. Maynard.

[The prepared statement of Dr. Maynard appears in the appendix.]

Senator ROCKEFELLER. Dr. Graham, could you please elaborate about the current measures of practice costs? And do you have any information on how the PPRC's geographic multiplier would affect rural physicians?

Dr. GRAHAM. I think we have touched on some of that in our earlier conversation. In our view, the measures of practice cost are still very crude and I do not try to suggest to you that we have the right methodology and everyone else in wrong. But it does appear to us that they are based heavily by relative economic indexes which take into account a broad variety of costs of goods and services in rural and urban areas and are not specifically focused on the costs of goods and services attendant to the practice of medicine.

So as a general point of critique, I would say that is why we believe there may be a disparity between what we think are equivalent costs of practice in rural areas to urban areas, at least in the area of our expertise, which is office-based primary care medicine, family physician practices.

The PPRC suggestion that there should be some continuing differential appears to us to be based largely on data which uses those other macro economic indicators, if you will, that are assessing more than the practice costs of physician practices.

Senator ROCKEFELLER. The AARP has expressed serious concerns that imposing an income test on a balance billing policy would effectively means test the benefit. Do you share this concern?

Dr. GRAHAM. I certainly understand their concern and I think that in that area we are probably in policy disagreement with them. As I understand the AARP's position, means testing of any benefits at any time is unacceptable. Our belief is, again, similar to something I think you said earlier in your opening comments. This is a nation which has been built upon the principal of progressive taxation. We believe that it is reasonable to give some protection of extra charges to beneficiaries, but that above that some type of means testing may be perfectly appropriate.

Senator ROCKEFELLER. I understand your concern that rural physicians be paid fairly and I share that. I would agree that we have to take a careful look at the special practice costs that are involved in treating a rural population. On the other hand, if we do not use a geographic multiplier, what will doctors in New York or Los Angeles say about the special practice costs they face?

Dr. GRAHAM. I think it is appropriate to split out those two issues and I would suggest to you that they are not often split out in this discussion, or this type of discussion—that is, the various of rural versus urban practice costsin West Virginia versus Connecticut versus Montana. As a separate issue then regional practice costs—Connecticut compared to Montana compared to Florida—I am far more comfortable about the lack of difference in rural urban practice costs within a given geographic area based upon the data that I have seen, than I am stating categorically that there are no practice cost differentials—Connecticut to Wyoming to Florida.

I think, however, that that is also reflective that the geographic variation data is very skimpy. Were it ever to be adequately demonstrated that there are real cost differentials, region by region, then I think based upon the philosophy that we are supporting with the RVS, which is that it is a resource-based relative value schedule, that we would acknowledge that different resource costs should be reflected in the payment to physician.

I do not believe that that has been demonstrated to date. Which brings me back to the original point that when you start the fee schedule, I think it ought to be equal fee for equal service. If when the data is compelling that there are different costs and different resources, then you make the change.

Senator ROCKEFELLER. Dr. Maynard, would you care to comment on the testimony of the American Society of Internal Medicine that limits on balance billing would encourage "mediocrity" among physicians?

Dr. MAYNARD. I do not think the American College of Physicians would share this policy conclusion. We do not favor a mandatory assignment policy for a number of reasons. We do believe that protection should be offered to the lower end of the population—the elderly, poor. And we have not come up with, as I said, a specific recommendation as to the level at which such mandatory assignment should be mandated.

I would say that coming from a State in which mandatory Medicare assignment is indeed the law and tied to licensure that there are some major problems with this. On the one hand, at the upper end of the extreme, it seems inappropriate that extremely wealthy elderly patients, who are embarrassed by the fact that the payments that their physicians receive from Medicare may not cover their office costs, should be prohibited from paying more. But more importantly, at the other end, for our students graduating from medical school, unquestionably they are choosing the better remunerated specialties simply because it is very difficult for them to practice in Massachusetts as they come out burdened with debt. This is a very discriminatory system at the present.

Now, one can argue that if through an RBRVS system one achieves the perfect form of reimbursement so that physicians are indeed appropriately paid for their services that one could in turn insist upon a wider level of mandatory assignment. I think that the College and many other people in the profession do not have total confidence that Congress, or whoever would institute such a law, would have ongoing vision for what is totally appropriate services and reimbursement.

Senator ROCKEFELLER. Under our current budget process, the Congressional Budget Office sets the base line based on projected increases in number of beneficiaries, also the volume of services and physician fees. Over the past few years, Congress and the administration have been forced to achieve targeted budget savings by reducing physician allowed charges.

How different is this from the concept of an expenditure target; and, in fact, is it preferable to allow physicians the autonomy to examine their own practice patterns rather than continue what we have been forced to do here year after year?

Dr. MAYNARD. Well, I think I would again return to the view that I expressed in my earlier testimony. Namely, that as opposed to an expenditure target or group of expenditure targets, regional or otherwise, we place much greater confidence on the appropriate implementation of practice guidelines that are developed by the medical community.

These have really been shown to work in small numbers of instances to date. I alluded to the studies that the Beth Israel Hospital and one at UCLA and I would again point to one of the Rand Corp. studies recently which defined the appropriateness of an expensive procedure, carodoendarterectomy. When this study was published, it had dramatic impact on the behavior of physicians and has already marketedly reduced the expenditures among Medicare recipients for this very expensive procedure.

This is the type of practice——

Senator ROCKEFELLER. Can you elaborate on that to me? Help me to understand that.

Dr. MAYNARD. Well, on that particular study or this general type——

Senator ROCKEFELLER. What you just described.

Dr. MAYNARD. What I described was, to get into more technical medical terms, if one found a narrowed corroded artery in a patient and felt that they might be at risk for stroke, many neurologists and surgeons—vascular surgeons—in this country recommended proceeding with an endarterectomy procedure to clean out that artery to help prevent a stroke at a later date.

Careful studies showed that this was not necessary, not appropriate, that one could follow these patients and that if indeed they did have such warning symptoms then move with the procedure. But that to do so on a prophylactic basis was not effective. And we have thereby eliminated a large number of inappropriate and expensive medical procedures. This is done over and over again in the medical experience and we can point to similar situations.

The Boston Hospital experience was looking at respiratory therapy and we eliminated a large number of procedures in respiratory care as a part of that study. This is a good way to go to save money.

Senator ROCKEFELLER. You have advocated closer utilization review and higher rates of claims denials for inappropriate care. I understand the logic in that. But doctors, I think, hate to have carriers and PRO's looking over their shoulders and questioning their judgment. It is the biggest complaint that we hear here. Also, it is complex administratively.

Are you sure that you want us to follow that policy and is there another way to control unnecessary volume growths?

Dr. MAYNARD. Well, this is as you say, a very complex issue. But I think that in the real world the medical profession recognizes that the payers are going to be concerned that the services for which they pay are indeed appropriate and that some form of monitoring is indeed appropriate.

What we believe is that the PRO's or other groups of payers can very appropriately look at broad patterns of utilization of procedures and to try and control inappropriate procedures when they are used in large numbers. Then it gets down to the issue of an individual provider, an individual physician, and then one has to look much more carefully. But, yes, be prepared to identify and implement payment denial for clearly inappropriate procedures.

Senator ROCKEFELLER. Thank you, Dr. Maynard.

Dr. Franaszek, I appreciate the suggest that under RBRVS fee schedule balance billing should be prohibited for services such as emergency services where the patient has no choice of physician. As you indicated the physician has no choice of patient.

Do you see this applying to all emergency room services or only to those that are really emergencies?

Dr. FRANASZEK. I think to all bona-fide emergency services.

Senator ROCKEFELLER. I didn't hear.

Dr. FRANASZEK. To all bona fide emergency services.

Senator ROCKEFELLER. To all?

Dr. FRANASZEK. Yes.

Senator ROCKEFELLER. There has been discussion of separate expenditure targets for surgical services. Do you think that there should be separate expenditure targets for all physician services that are provided in hospitals?

Dr. FRANASZEK. I cannot answer this question because it is out of my area of practice. I think emergency medicine constitutes a somewhat different area of practice. It does not make it possible for me to comment on this.

Senator ROCKEFELLER. Dr. Maynard?

Dr. **Maynard**. We do not favor the idea of different expenditure targets for surgeons or any other group. I would have to say that if the Congress decides to implement an expenditure target, it should be a global target for the country and that some specific, fair implementation methodology—whether it be through the determination of a conversion factor —would be the appropriate way of controlling costs.

Senator **Rockefeller**. All right. I thank all of you. It has been, I think, a useful series of testimonies and I think that we have—both the AARP and the physicians acknowledge that there are some very thorny problems that we face. There are clear differences of view. We have an enormous task ahead of us and a reasonable amount of time to try and settle on a solution.

I thank you for your presence and this hearing is adjourned.

[Whereupon, the hearing was adjourned at 4:40 p.m.]

APPENDIX

ALPHABETICAL LISTING AND MATERIAL SUBMITTED

PREPARED STATEMENT OF SENATOR MAX BAUCUS (MARCH 17, 1989)

Thank you, Mr. Chairman.

I commend the Chairman for choosing "Physician Payment" as the topic of this hearing. For the past 6 years much of our deliberation has centered on the effect of prospective payment on hospital payments. I, and others, have focused attention particularly on the worsening plight of isolated rural hospitals

Although our discussions on the Finance Committee during the 1980s might have been called the "Decade of the Hospital", I believe the 1990s will be called the "Decade of the Physician."

I am concerned that the Federal government, as the country's largest health care insurer, has not provided the right incentives for physicians.

A recent example is a series of punitive regulations on "sub-standard care" that have the potential to break down the established peer review system, increase medical liability claims, or increase the costs generated by "defensive medicine."

These regulations raise a wall between providers and the government. A wall that will not improve the quality of patient care.

We need more dialogue not more walls.

And what has our current physician payment system led to?

For some health care consumers, these distorted incentives have contributed to the best health care that 11.2% of the Gross National Product can buy. Others, however, have been left out of this economic equation and have limited or no access to health care.

Despite a "physician glut," with calls to cut back on the class size of medical schools, there are rural areas of this country that cannot get a doctor to set up a primary care practice.

Why is that?

Well, any of these smart young graduates, with thousands of dollars of school loans pending, can read the message between the lines of our current approach to physician payment, and that message is not that we value primary care services in underserved areas.

What exactly is that message?

We're telling them:

- Don't go into primary care. Go into a specialty that does procedures that we reimburse much better.
- Don't go into an underserved rural area where you're needed. Go into an "over-doctored" urban or suburban area where Medicare will pay you 30% more for the same service.
- Don't practice obstetrics or see young children. Medicaid fees won't cover your malpractice premiums. It's only the next generation.

Mr. Chairman, we need to change the message. Much needs to be done. I look forward to working with you on such bills as the Rural Health Manpower Assistance Act, that we introduced on February 7th, that gives an additional 5% bonus for doctors providing primary care services in isolated rural areas.

Today, I hope to hear about real progress towards more fundamental changes in the messages we are sending our young health care professionals.

Let's get moving on a fair resource based relative value scale. Let's get moving on fair geographic multipliers. Let's attract some doctors to the areas of our country where they're needed.

Thank you.

PREPARED STATEMENT OF SENATOR MAX BAUCUS (APRIL 20, 1989)

Mr. Chairman, I want to thank you for the speed with which you have scheduled hearings on Medicare physician payment reform. This is an issue that demands our most diligent efforts.

The current "customary and prevailing" methodology has led to unreasonable and inequitable payment for many physician services. Instituting a fee schedule based on resources will provide an important signal to the young men and women entering the medical field. It will tell those young doctors that this country values primary care.

But the fee schedule also addresses the extraordinary variation in payment that is based on where a doctor is practicing. Why should a doctor in Montana be paid 40% less for the identical service provided in New York. Why should Medicare pay more for a service in a city that already has a glut of doctors. Let's reintroduce some basic fairness to this system, and tell doctors that they can earn a decent living by practicing in a rural area where they are really needed.

But payment reform carries some risks.

We will need to look at the out of pocket costs by seniors, and make sure that the plan reduces those costs while maintaining adequate access. I would also like to see some recognition of the real problems that medical liability is currently presenting to the health care system, and the escalating costs being generated by "defensive" medicine.

I look forward to hearing today's witnesses discuss these, and other, important issues raised by physician payment reform.

PREPARED STATEMENT OF SENATOR LLOYD BENTSEN

Mr. Chairman (Senator Rockefeller), I want to thank you for holding this hearing today to give us the opportunity to hear the recommendations of the Physician Payment Review Commission. The Commission's recommendations will be extremely important to the Congress as we begin a long overdue reform of the way in which physicians are paid under the Medicare program. We are also fortunate to have with us today Dr. Bill Hsiao, the principal researcher on the Harvard relative value study.

The current method of payment for physician services under Medicare has become extremely confusing, has created some distortions that may favor certain types of services over others, and has led to many geographic variations in payment amount that appear not to be related to any legitimate differences in the cost of providing services.

In the Consolidated Omnibus Budget Reconciliation Act of 1985, Congress created the Physician Payment Review Commission, and included a provision from a bill that I cosponsored with Senators Dole and Durenberger which mandated that the Secretary of Health and Human Services carry out a study of the use of a relative value scale for physician reimbursement. Dr. Hsiao and his colleagues have completed the first phase of that study, and the Commission has analyzed the results of the study and has refined the relative value scale. The Commission has held extensive hearings at which all the various medical organizations and beneficiary groups have commented on the Harvard study, and we look forward to hearing its recommendations. We are also very interested in the other recommendations of the Commission, since physician payments under Medicare have been growing at a 15 percent annual rate, with serious budget implications for the Federal Government and increased out of pocket costs for beneficiaries.

We still have much work to do to reform the physician payment system, but today marks an important milestone on the way to that reform. I look forward to hearing the witnesses, and to continuing to work with the Commission on this important issue.

PREPARED STATEMENT OF JOSEPH F. BOYLE

My name is Joseph F. Boyle, MD, Executive Vice President of the American Society of Internal Medicine (ASIM). I appreciate the opportunity to express the views of internists and internists-subspecialists nationwide on reform of the Medicare system of payment for physician services, with particular attention to the proposals just released by the Physician Payment Review Commission (PPRC).

ELEMENTS OF COMPREHENSIVE REFORM

ASIM believes that an effective, comprehensive, and long-term approach for payment reform should consist of the following elements:

1. Implementation of a fee schedule based on the Harvard resource based relative value scale (RBRVS), as called for by the Physician Payment Review Commission.

The PPRC has called on Congress to enact legislation this year to mandate a Medicare fee schedule based on the RBRVS being completed by Harvard University, with partial implementation taking place within six months of enactment, and full implementation over two years. Geographic differentials in payment would be limited to differences in the costs of providing services. The RBRVS would for the first time link Medicare payments with the work or resources (time, mental and physical effort, judgment, and overhead) required to provide physician services.

ASIM is particularly pleased that the PPRC, following an extensive review of the methodology and raw data collected in the Harvard study, consultation with outside experts, and testimony by numerous physician organizations, has concluded that the basic methodology of the Harvard RBRVS is sound. Further, ASIM agrees with she Commission that the estimates of physician time and effort developed by Harvard should be used as the initial basis for that component of the RBRVS in a new Medicare fee schedule. Although the PPRC has identified areas where It and Harvard are undertaking further refinements, it is extremely significant that the Commission has rejected the views of those who argue that the RBRVS is inherently "flawed", or that sufficient refinements cannot be made within the next several months in order to permit implementation as early as April, 1990.

It is also important to recognize that the Harvard RBRVS, and the recommendations of the Commission, reflect Congress' own interest in establishing a more rational basis for determining physician payments that based on the resource costs of providing those services. Both the Omnibus Budget Reconciliation Acts of 1985 and 1986, which mandated the development of an RVS based on resource costs, expressed this desire. *Congress should now move forward and enact legislation, as recommended by the PPRC, to mandate that implementation of a fee schedule based on the RBRVS beginning in April 1990, with full implementation taking place within two years. The initial dollar conversion factor should be established at a budget neutral level, as recommended by the PPRC.*

The Commission is also recommending that the Medicare fee schedule determine payments to all physicians, including those already paid under separate fee schedules. ASIM strongly supports this recommendation, and urges Congress to mandate that existing separate fee schedules for radiology and anesthesiology be incorporated into the new RBRVS fee schedule.

ASIM similarly believes that it would be inconsistent with the PPRC's recommendation for Congress to require establishment of additional separate fee schedules for subsets of physician services, such as surgical procedures. As this committee is aware, the American College of Surgeons (ACS) has proposed a separate fee schedule for surgery only. Under this proposal, the surgical fee schedule would be established at a budget neutral level. This proposal ignores one of the major advantages of establishing a uniform fee schedule based on the Harvard RBRVS: the ability to make comparisons on the relative work of physicians both between and within specialties. Without being able to make such comparisons, it is impossible to correct distortions in the existing pricing system that now favor technological procedures over evaluation and management services. Simply reallocating resources within surgery by partial use of resource costs would in no way correct the disparity in reimbursement between physicians' evaluation and management (or cognitive) services and technological procedures.

Moreover, a budget neutral target for surgical services would preclude any increase for evaluation and management services, thus eliminating the advantages that would accrue to the medical care system from improved reimbursement for those historically undervalued services. Separate fee schedules are also far more confusing and complex to administer than a uniform, inclusive RBRVS fee schedule that applies the same rules of payment to all services by all physicians, regardless of specialty. we believe that whatever Congress decides should be done with the physician payment system, all physicians, in all specialties, should be wiling to play by the same rules.

ASIM also strongly supports the Commissions proposal to limit variations in payment levels by region only to actual differences in the cost of providing services (overhead). As discussed later, *this will significantly improve access to physician services in underserved rural communities.*

2. Establishment of a "safety net" to protect low-income beneficiaries from out-of-pocket expenses that they cannot afford.

As part of comprehensive reform of physician payment, ASIM supports appropriate limits limits on balance billing to low-income beneficiaries. The PPRC's proposal to require acceptance of assignment for all individuals whose Medicare cost sharing must, by law, be paid by their respective states (i.e., all those whose incomes are below the U.S. poverty level) is consistent with this principle.

ASIM strongly believes, however, that it is inappropriate and unnecessary to establish an overall limit on charges to all beneficiaries at some percentile level above the payment levels established by the fee schedule, as the Commission has recommended. Such a requirement, in ASIM's view, is a prescription for mediocrity. It is well recognized that in every field—including engineering, law, architecture and accounting—there are some individuals that have more experience, greater expertise, and offer a better service than the norm for their field. Those individuals typically and appropriately charge more for their services than the average. This is as true in medicine as it is in any other field of endeavor. Patients should have the right to select physicians who bring greater skill to treating their individual problems, and who therefore have an appropriately higher charge. Limiting all physician fees to some predetermined percentile above the RBRVS fee schedule would preclude that choice. Any fee schedule, even one based on resource costs, by its nature represents a standard or average; balance billing is the only way to recognize differences in the skill and training of individual physicians, and in the needs and desires of individual patients.

3. Expansion of policies designed to develop the scientific knowledge—and the means—to assure that only effective services are reimbursed by the Medicare program.

ASIM has previously provided Congress with a paper titled "Controlling the Volume of Ineffective Medical Services: A Plan of Action" that included 14 specific recommendations on the volume issue. The recommendations include increasing medical review of services provided in organized outpatient settings; substantially increasing the resources devoted toward developing practice guidelines, particularly for high volume procedures; studying ways to bundle certain physician services; increasing data collection and analysis; and instituting measures to improve the effectiveness of medical review. ASIM strongly supports the PPRC's proposals for a significant expansion of funding for effectiveness research and the development of practice guidelines.

We urge Congress, however, to proceed cautiously before mandating measures that could diminish access and quality of care, such as the PPRC's recommendation for national expenditure targets. *Unlike the Commission's recommendation on the RBRVS fee schedule, which reflects over ten years of debate and evaluation, and two and one-half years of intensive work on the part of the PPRC, the expenditure target proposal has not undergone critical scrutiny.* This concept has not been the primary focus of the Commission's hearings and work over the past several years. Consequently, the Commission has not had the benefit of the same type and degree of expert advice, public comment, and research that were reflected in its recommendation on the RBRVS fee schedule. This is unfortunate, particularly given the fact that the expenditure target approach could have even greater ramifications for the quality and accessibility of medical care in this country than a fee schedule.

The purpose of the expenditure target approach is to limit services provided to Medicare beneficiaries. As such, it must be recognized as a form of rationing. According to the dictionary, "ration" means to restrict to limited amounts. The Commission acknowledged in its March 1988 report to Congress that "the intent of expenditure targets is to make explicit to physicians the limits of the resources society has decided to make available for health care . . ."

Presumably, the Commission intends for only "unnecessary" or "ineffective" services to be eliminated. Given tee lack of data and consensus on the effectiveness of different medical services and procedures—and the inherent contradiction in attempting to set a limit on overall expenditures without any public consensus of how much should be spent on medical care—it takes a large and unjustified leap of faith to presume that only "waste" will be cut from the system.

Put into individual terms, expenditure targets can only work if individual doctors decline to provide certain services to their patients that they otherwise would have provided. *Without a scientific basis for making such a determination, however, it is just as likely that "effective" as "ineffective" services will be denied, particularly in grey areas where there is no clear consensus on what is the best way of treating a particular problem.* Consequently, it is the patient, not the physician, that is at risk under the expenditure target concept. This distorts the physician's traditional role as advocate of his or her patient, by placing the physician in the position of limiting services to patients in order to meet predetermined targets established by the federal government.

It is also unclear how the medical profession can collectively control utilization across the country in order to meet the expenditure target. An individual physician who practices a conservative style of medicine would still be financially penalized if overall expenditures exceed the expenditure target limit. Similarly, lower cost regions of the country will be at risk for higher utilization of other parts of the nation. Physicians in one specialty will similarly be at risk if physicians in other specialties increase their volume of services. Consequently, expenditure targets place individual physicians at risk for behavior by their colleagues that is outside their own control. Moreover, there is no organized system of utilization review now in place nationwide that would enable the profession to collectively control the volume of services.

A strategy designed to obtain the knowledge-and the means—for reviewing and evaluating the effectiveness of different ways of treating patients offers far more potential than expenditure targets for *appropriately* controlling the volume of ineffective medical services, without compromising patient care. ASIM commends Senator Mitchell for introducing the Patient Outcomes Research Bill, which will greatly expand federal support for activities to develop and disseminate such guidelines. Such an approach should be given a chance to work before Congress concludes expenditure targets are necessary or desirable.

4. Enactment of interim measures for FY 1990 that are consistent with long-term reform based on RBRVS.

ASIM recognizes that Congress has an immediate interest in moderating Part B expenditures as part of FY 1990 deficit reduction. Consequently, we would support appropriate measures to reduce spending, provided that they are fair, reasonable, and not in conflict with the objectives of long-term reform. Capping prevailing charges for radiological, anesthesia, and surgical (RAS) services, after adjustment for cost of practice, at some percentile above the national mean (e.g. 120th percentile), and increasing the existing floor (now set at the 50th percentile of the national mean) for primary care services, could achieve FY 1990 savings in a way that is consistent with long-term reform based on the RBRVS. All other primary care services should receive the full MEI increase. Such an approach is far more fair than the across-the-board cuts in RAS services proposed in the President's budget, since it would reduce payment for RAS services only in those areas that are now reimbursed well in excess of what can be explained or justified simply on the basis of higher practice costs. It would lower payments for those services that are most likely to be indentified as being overvalued under and RBRVS fee schedule with geographic multipliers limited to overhead, and increase payment for those services most likely to be identified as undervalued.

ASIM cautions Congress, however, to consider the magnitude of cuts that have already taken place in Medicare Part B before deciding on the extent of further cuts. In addition, ASIM strongly believes that no portion of Medicare should be considered to be off-limits, and that Congress should consider appropriate increases in revenue—such as an increase in so-alled "sin" taxes—in its efforts to achieve deficit reduction.

IMPACT ON ACCESS, QUALITY, OUT-OF-POCKET EXPENSES, COSTS, AND VOLUME

ASIM believes that this comprehensive approach to payment reform will have a favorable impact on several objectives that Congress, the medical profession, the Physician Payment Review Commission, and others agree should be driving long-term reform.

Improving Access and Quality.

By substantially improving payments for undervalued primary care services, particularly in rural communities, payment reform with an RBRVS fee schedule at its core will correct distortions that now act as a barrier to provision of these services in underserved areas. Physicians no longer will be penalized for entering primary care specialties or locating in underserved rural areas. The interim measures proposed above (capping prevailing charges for RAS services and raising the floor on payments for primary care) will also help move the system in the appropriate direction.

An RBRVS fee schedule, by neutralizing incentives that favor one type of care over another, will also enhance quality. *For the first time, physicians will not be biased by higher payments for the work involved for some services compared to others in making decisions on how to best treat their patients.* Since the amount of time a physician spends with patients correlates closely with quality of care and patient satisfaction, the RBRVS—by no longer penalizing physicians for timeconsuming cognitive services—will also enhance the overall quality of physician-patient encounters. As practice guidelines enable physicians to identify procedures that can be avoided without compromising patient care, physicians will be able to spend the time needed to explain to patients *why* certain tests and procedures are *not* needed to treat or diagnose their particular problem.

Protecting Beneficiaries from Excessive Out-of-Pocket Expenses

Establishing limits on balance billing to low-income beneficiaries will protect those who cannot afford to pay more than the Medicare-approved amount under a fee schedule, while maintaining the basic right of beneficiaries to choose and contract with any physician of their choice, including physicians with special expertise who may charge relatively higher fees. *RBRVS-based reform will also improve overall acceptance of assignment,* particularly for undervalued evaluation and management services.

Patients' financial contributions to surgical care will also be substantially reduced. According to the PPRC's simulations, it would take 181 intermediate office visits at the slightly higher co-insurance level under the RBRVS (a $1.41 increase) to cancel out the savings that a patient who undergoes bypass surgery would receive through reduced co-insurance for just that one procedure (a decrease in co-insurance of $256). The majority of beneficiaries with Medigap insurance would also be protected from increases in co-insurance for any services.

Making Expenditures More Moderate and Predictable

Although implementing the RBRVS fee schedule in a budget neutral manner—as recommended by PPRC—will not by itself reduce expenditures, the impact on the budget of future increases in payment rates will be far more predictable than under the existing "customary, prevailing and reasonable" charge system. By tying future increases in the conversion factor to a reasonable measure of inflation, Congress can assure that price increases do not exceed that which is necessary to maintain the same level of service to beneficiaries. In addition, by neutralizing incentives that may encourage excessive reliance on certain technological services, overall costs can be expected to moderate in the long run. *As long as invasive procedures are paid more for the work involved than other services, there will be an inherent bias toward doing more technological procedures—a bias that conflicts with any strategy designed to get increases in volume under control.* Development of practice guidelines can also achieve future cost-savings, particularly if developed first for those services that have experienced the greatest increases in volume, such as, diagnostic and surgical procedures. Based on a CBO analysis of a variation of the proposal for capping prevailing charges for RAS services, that recommendation would appear to offer the potential of substantial FY 1990 savings in a way that is consistent with RBRVS based reform.

Summary and Conclusions

In conclusion, ASIM strongly urges Congress to establish policies this year that would (1) mandate implementation of a RBRVS fee schedule beginning in 1990; (2) protect low income beneficiaries from charges that they cannot afford (3) provide a scientific basis for controlling the volume of ineffective services and (4) reduce FY 1990 expenditures in a way that is consistent with long term reform based on the RBRVS. ASIM stands ready to assist the committee in bringing about reform based on these elements.

Enclosure.

QUESTIONS SUBMITTED BY SENATOR PACKWOOD

1. Why do you oppose a separate fee schedule for surgery, as proposed by the American College of Surgeons? What, if any, effects on internists do you believe it would have?

2. The American Association of Retired Persons endorses the PPRC recommendation to have physicians bill Medicare directly. I am concerned about the potentially significant increases in Part B expenditures which could result from the additional claims which are currently not filed by beneficiaries. Could you give me your views on how physicians will respond to this proposal? Would their response differ depending on whether physicians could bill patients for the filing costs?

3. We are faced with saving $2.7 billion from Medicare this year and perhaps even more in future years. The RBRVS absent volume controls such as expenditure targets would probably, at best, postpone any real savings for at least 3 and maybe

many more years. Since we have a proposal in hand that offers some ways to save money now, why should we wait?

RESPONSES TO QUESTIONS SUBMITTED BY SENATOR PACKWOOD

This is a response to your follow-up questons regarding our testimony at the April 20, 1989 hearing on physician payment reform. I regret the delay in responding to your letter.

First, you asked us to elaborate on our reasons for opposing a separate fee schedule for surgery, as proposed by the American College of Surgeons (ACS). The attached analysis of the ACS proposal explains the reasons for our strong objections to a separate fee schedule for surgery or any other subset of physician services. The Physician Payment Review Commission (PPRC) shares our view: it specifically rejected separate fee schedules in favor of a unified fee schedule based on a resource based relative value scale (RBRVS), which would include all physician services. A unified RBRVS fee schedule represents the only method that would allow for a comparison of the relative work involved in surgical and medical services based on the same criteria, with relative values established on the same scale. Such comparison would allow for improvements in reimbursement for evaluation and management services that have been undervalued based on the work required, as well as appropriate reductions in payments for services that are overvalued based on the same criteria. A separate fee schedule for surgery would preclude such a comparison.

Moreover, the American College of Surgeons proposes that the surgery fee schedule be "budget neutral", meaning of course that overall expenditures for surgery would not be any less under the proposed fee schedule than under the current system. Consequently, although some individual surgical procedures might undergo reductions in payment, the overall amount of dollars spent on surgical care would not diminish. This would preclude any real increase in reimbursement for undervalued evaluation and management services provided by internists and other physicians, since such increases will be financed in large part by a shift in dollars from overpriced surgical services to evaluation and management services. The ACS proposal therefore has a very significant—and clearly detrimental—effect on internists and their patients. This could create severe access problems in those communities, particularly rural areas, where internists currently are providing evaluation and management services at a loss to Medicare patients.

You also asked for our views on the PPRC's recommendation to require physicians to submit all Medicare claims directly to the program, even those being billed on an unassigned basis. ASIM encourages members to file all claims on behalf of their Medicare patients, independent of the decision to accept assignment on that claim. For most physicians, this requirement would not create an undue hardship. In fact, it is standard practice in most physicians' offices to assist all Medicare patients in submitting claims to the program. It is possible that in some offices this requirement could impose additional costs and administrative difficulties, if they currently do not provide this service to their patients and do not have the staff resources to do so. We believe that most physicians would accept this requirement without billing patients for the filing costs if overall reimbursement from the Medicare program is fair and reasonable. As long as the program continues to grossly undervalue services provided by internists, however, any additional administrative costs created as a result of congressional or agency mandate can create a real economic strain on internists' practices.

ASIM agrees that significant increases in Part B expenditures could result if additional claims are filed on behalf of beneficiaries that otherwise would not have been filed. A study conducted for the PPRC by Peter McMenamin found that 11 percent more beneficiaries filed claims (or had claims filed for them) in 1985 rather than 1983, which he attribute 20 percent of the total growth in outlays to these beneficiaries. However, if this means that beneficiaries are receiving benefits and appropriate care to which they are by law entitled, then ASIM believes that it is not unreasonable for Medicare to assume these increased expenditures. It is essential, however, that such increases in outlays resulting from more claimants not be erroneously attributed to physicians increasing the volume of services provided to Medicare patients. This is particularly important if Congress decides to mandate expenditure targets, since targets could put physicians at risk for increases in outlays that are a direct result of more claims being filed (in response to congressional mandate), not of physicians performing more services.

Finally, you questioned why Congress should wait on enacting expenditure targets, since such targets presumably can achieve short-term savings, while the "RBRVS absent volume controls such as expenditure targets would probably, at best, postpone any real savings for at least three or maybe many more years." ASIM recently provided you with a copy of our proposal for establishing an aggressive policy on outcomes research and practice guidelines that would result in direct savings to the federal treasury within the same basic timeframe envisioned by advocates of expenditure targets. A copy of ASIM's proposal is appended for your review (Attachment B) (made part of the Committee files). By developing guidelines first for high volume procedures and those subject to payment reductions under the RBRVS fee schedule, by requiring that those guidelines be developed in an expeditious manner, by incorporating guidelines into coverage decisions (while maintaining professional judgment to deviate for cause), by requiring PPRC to monitor and report to Congress on the effectiveness of practice guidelines on controlling volume, and by studying the feasibility of creating a practice pattern assessment system, Congress can be assured that this alternative will appropriately reduce the volume of ineffective services, without the risks inherent with expenditure targets. Our strong objections to expenditure targets are summarized in the attached discussion paper (attachment C) (made part of the Committee files).

PREPARED STATEMENT OF SENATOR JOHN H. CHAFEE (MARCH 17, 1989)

Mr. Chairman, I can not tell you how pleased I am that the Committee will today hear the PPRC's recommendations for reform of physician payments under Part B of Medicare. Unfortunately, I will not be able to stay long because of other committee obligations, but I will study the record very carefully.

In each of the past half dozen years, we have dealt with the issue of physician payment in budget reconciliation. Physician payment is the single most contentious issue in our negotiations with the House. As one of the "designated hitters" in this area I must say that I have grown weary of trying to tweak the physician payment system here and there to reduce costs. So it is with great anticipation and some relief that I review the PPRC's recommendations. A resource-based fee schedule has a good fighting chance of injecting some logic into our physician payment system, and the PPRC's recommendations strike me as a sound beginning.

Mr. Chairman, I just want to point one thing out that may make some of us feel better about our track record. We on this committee are so often put in the position of having to make policy decisions in the heat of the budget process. This is not the way I or anyone else would like to do it, and we do our very best to be cautious and consider the policy implications of what we do. Occasionally, it seems, we do actually achieve sensible solutions—something I could not help but notice in going through the PPRC's recommendations. When faced with the question of mandatory assignment during 1986 reconciliation, I and others developed a compromise system which came to be known as MAACs: Maximum Actual Allowable Charges. We hatched it in the dead of the night and hammered it out over the next two days. So it is gratifying and reassuring to see that the PPRC—after substantially longer, more thoughtful, and better-informed deliberations—has come to the same conclusion on mandatory assignment, and has recommended a refined version of our MAAC system.

In closing, I want to commend Drs. Hsiao and Lee for taking on a task of such superhuman proportions, and doing it with such professionalism. We like to take on monumental tasks in this committee—tax reform, welfare reform—but we have to start out with a sound foundation. You have given us that foundation, and wherever this process takes us, we will be indebted to you for your hard work.

PREPARED STATEMENT OF SENATOR JOHN H. CHAFEE (APRIL 20, 1989)

Mr. Chairman, with this hearing we continue our expedition into the realm of physician payment reform. It is challenging terrain, but it is an expedition we must undertake. We are lucky to have had the benefit of expert guides like Dr. Hsiao of Harvard and Dr. Lee of the Pysician Payment Review Commission, who testified at our last hearing and who have done the bulk of the work in charting this territory. Today we will begin to fill out the map with the views of provider and beneficiary groups.

Whether we like it or not, payment issues have a major impact on health care decisions throughout the system. This is a fact we need to keep foremost in our minds as we proceed with this task. Whatever system we produce, we need to know—to the very greatest extent possible—where it provides incentives, and for what, where it provides disincentives, and for what, and where it is neutral.

Becuase of its tremendous role in health care financing, Medicare Part B is like the proverbial 800-pound gorilla. The changes we make in Part B reimbursement will ripple through the entire system. They will affect everyone who purchases or provides health care. For better or for worse, the entire health care industry will adjust its behavior in response to what we do here. That is why we need to be extremely careful that we know what we are doing.

As delicate and difficult a process as it may be, I am delighted that we are forging ahead with physician payment reform. A resource-based fee schedule has a good chance of injecting some logic into our physician payment system, and the PPRC's recommendations strike me as a sound beginning. I look forward to hearing the witnesses' views.

PREPARED STATEMENT OF FRANK DELAY

Mr. Chairman, and members of the Subcommittee, I am Frank Delay, a member of the Board of Directors of the American Association of Retired Persons (AARP).

We appreciate this opportunity to appear before the Subcommittee to present our views on physician payment reform.

The Association continues to support the goal of revising Medicare's physician payment methodology through the use of a fee schedule based on a resource based relative value schedule. We have had the opportunity to review a number of physician payment issues from the beneficiary perspective with the Physician Payment Review Commission (PPRC), in hearings and in meetings with their staff.

Our testimony today covers several areas: (1) problems with the existing payment system; (2) recent actions in physician payment reform, and the beneficiary community's interest in controlling the growth in Part 6 expenditures; (3) AARP's perspective on payment reforms, the fee schedule revisions suggested by the PPRC, and the need for a better understanding of the impact of payment proposals on beneficiaries; (4) other important elements of the PPRC plan—elements that are necessary to any payment reform plan—such as beneficiary protections and volume controls; (5) the American College of Surgeons' proposal; and, (6) a summary of what AARP sees as the key elements which need to be incorporated in any physician payment reform initiative.

BACKGROUND

Physician payment reform has generated a complicated, technical debate among government policy and budget officials, researchers, and physician specialty and subspecialty associations. That debate is vitally important, but we think it useful to go back to the basics when assessing issues as complicated as physician payment reform.

AARP approaches this issue with what we hope is not a novel premise—that Medicare exists to assure financial access to health care for the 33 million elderly and disabled individuals insured under the program. Medicare has brought to its beneficiaries access to care generally comparable to the rest of the population and provided financial protection for the cost of covered services. But rapidly rising costs are eroding that protection.

For me and for 33 million other Americans—and for the rest of the population as they age—Medicare is not a technical policy issue—it is our health insurance plan. It was enacted because the nation recognized that a Federal social insurance program—Medicare—was appropriate and necessary to support health benefits coverage for the aged and disabled, with Medicaid providing means tested coverage for the poor. The reason was, and reMins, that the traditional vehicles for support of health benefits are less available to the elderly. For example, federal tax incentives provide substantial governmental support for the many younger, working individuals in employer-based group health insurance—at a cost estimated at about $30 billion in tax expenditures in FY 1990. That support and numerous other advantages of group health benefits are less available to elderly persons.

PROBLEMS WITH EXISTING PAYMENT SYSTEM

AARP believes that there are five fundamental problems with the existing payment system that must be addressed:

- The payment system has been inherently inflationary since its inception in that payment levels rise with the increase in billed charges (subject to some constraints);
- The fee-for-service methodology encourages the provision of an increasing volume of visits and tests;
- The payment methodology reflects—and contributes to—numerous distortions in the medical care market often based on the charging patterns existing in the

early 1970s. These distortions account for unjustifiable differences in fees among different types of services, and among different locations.

- **The system does not provide adequate financial protection to beneficiaries against charges over and above what Medicare determines to be reasonable; despite recent improvements in this regard, physicians still have the option to extra-bill the beneficiary after Medicare has decided on the charge which it determines to be reasonable.**
- **Finally, the system is enormously complicated for beneficiaries, physicians, and** the government to understand and to deal with. Could any member of the Subcommittee give a complete description of the determination of the reasonable charge, the PAR/non-PAR program, assignment, computation of the MAAC limits, and procedures for filing bills and getting them paid? Yet every day, beneficiaries and physicians have to try to wend their way through that very system.

RECENT ACTIONS, AND BENEFICIARY INTEREST IN CONTROLLING EXPENDITURE GROWTH

Over the past few years, the Congress has addressed a number of these issues. The creation of the Physician Payment Review Commission was an effort to begin working toward long-range reform of the system. In addition, shorter-term legislative actions have been taken as well. Congress has imposed a number of constraints on physician payments—and *has always accompanied those constraints with beneficiary protections.* Those protections are particularly important because they help assure that the federal savings in payments for physicians' services are not shifted to the beneficiary in the form of increased extra-billing. The participating physician (PAR) program and the maximum allowable actual charge (MAAC) limits have helped to increase the assignment rate. Equally important, they provide a framework that, with enhancements, can help protect the beneficiary from having payment reductions passed on to us under any future payment reforms. Let me state clearly that in any further reform of the system, beneficiaries should share in any savings achieved.

The PPRC's March, 1988 report provides a useful graph, which I have attached to my testimony, which highlights the fact that the beneficiary protection initiatives (PARs and MAACs) have slowed the growth in extra-billings—which until recently had been the fastest growing portion of out-of-pocket payments by beneficiaries under Part B. Given continuing and enhanced financial protections against extra-billings, the most serious financial problem that beneficiaries now face in Part B of Medicare is that *overall spending* continues to grow too fast. This is an important issue for beneficiaries because we share substantially in the cost of that spending growth through Part B premiums, deductibles, coinsurance, *and* taxes.

For example, annual Part B premiums have increased 91 percent since 1984—from $175.20 to $334.80, exclusive of the monthly catastrophic coverage premium that all Part 6 enrollees will pay.

AARP believes that any physician payment reform, assuming protections against extra-billing, must be more than simply adjusting payment levels to create greater equity among physicians. Reform must also address rapid expenditure growth under Part B of Medicare. In fiscal year 1988, beneficiaries paid $1.8 billion for the Part B deductible, and $7.14 billion in coinsurance. As a beneficiary who pays for a substantial portion of Part B payments through my premium, deductibles, coinsurance, and taxes, I want to be sure that overall spending controls are included.

It is important to note that the spending growth that we see in Medicare is not some rapid increase in beneficiary induced demand. The staff of the Congressional Budget Office estimated in December, 1988 that the increase in Part B spending from 1988 to 1990 was derived from three sources: price increases (19 percent); population increases (23 percent); and utilization/intensity increases (58 percent). These utilization/intensity factors include physician-induced demand (partially to accomodate to price constraints), unbundling and provision of more complicated services, and technological advancements. If there were any increase in patient-induced demand, it would be a subset of this number.

However, increases in patient-induced demand are not likely a large factor in the remaining spending increase. As I discussed earlier, there are substantial financial barriers to such demand—the initial deductible, the 20 percent coinsurance, and the extra-billing. The physician is generally the decisionmaker when it comes to the provision of medical services.

As the Subcommittee is only too well aware, the pressures to achieve savings in Medicare will continue into the forseeable future. Whatever new system you devise must not only provide a far more rational system, but also be able to accomodate future federal budget pressures without harming the integrity of the program.

AARP VIEWS ON PAYMENT REFORM

As I noted earlier, AARP continues to support reform in Medicare's physician payment methods in order to enhance the ability of Medicare to provide financial access to health services, and financial protection for beneficiaries for the cost of those services. The initial phase of the debate on physician payment reform has focused on adjusting payment levels among types of physicians' services and the geographic areas in which those services are provided. That is, of course, an important policy and technical issue, and one of great interest to the various segments of the physician community. The debate on how best to implement Medicare's fundamental purpose—the protection of beneficiaries and the assurance of continued access to affordable care—has just begun.

RVS REVISIONS, PRACTICE COSTS, AND GEOGRAPHIC MULTIPLIERS

A great deal of work has been done by PPRC and others to quantify, assess, and revise payment schedules for physician services. The original Resource Based Relative Value Schedule (RBRVS) developed at Harvard has been subject to a great deal of debate, and the PPRC has developed substantial modifications in the Harvard methodology. These include revisions in the method of determining overhead and practice costs, elimination of specialty differentials, and the use of global fees.

AARP concurs with PPRC's recommendation that a practice cost index reflect only overhead costs. We are concerned, however, that the potential impact of a geographic multiplier on beneficiaries' cost-sharing has not been carefully analyzed. In principal, since Medicare is a national health insurance program, beneficiaries should be provided equal financial protections and burdens for similar services wherever they reside. The precise means by which legitimate variations in cost should be included requires further work. It is reasonable to assume that some type of geographic adjustment is necessary to account for differences in costs such as rent and labor.

While the impact of some of these changes remains unclear, the Commission's continuing efforts and future plans to revise the fee schedule methodology will be important if the Congress chooses to make use of the RBRVS approach in enacting physician payment reform.

IMPACT ON BENEFICIARIES

While most of the debate and technical revisions have centered on issues concerning the physician community, AARP believes that it is equally important to recognize and assess the beneficiary impact of the relative value scale as well as other reform possibilities before you proceed.

The beneficiary impact of revising the fee schedule arises because a fee schedule changes the payment rates, and therefore the coinsurance rates. Thus, when you hear about payments for certain procedures or services, or in certain areas, being raised or lowered by 10 percent or 20 percent, you should recognize that you are making similar changes in coinsurance.

This concern about the coinsurance effects of fee schedule changes may appear to be self-evident, but it must be assessed carefully, because the payment changes create provider and beneficiary incentives which conflict. If you raise the amount I have to pay in coinsurance for primary care services, making those services more costly for me to receive, you tend to impose an increased financial barrier to my seeking care. Yet a major thrust of the RBRVS seems to be to encourage the provision of that same primary care service by increasing the provider's payment for primary care. The physician may be more likely to provide the service, but the patient is exposed to a greater financial barrier to that same service, which may make them less likely to seek the care. This is an important issue since primary care is typically the entry point to the medical system. This could impose the greatest problems for chronically ill persons who need frequent physician visits. Comparable problems arise as payments increase and decrease in specific geographic areas. For example, if payments in certain rural areas are increased, as they would be under the PPRC approach, coinsurance for individuals in those areas increases as well, again creating potentially conflicting physician and patient responses.

Extra-billing and assignment implications also need to be understood and assessed carefully. Increases in payment rates may make it less likely in the short-term that some physicians would extra-bill, while decreases would appear to make it more likely that others would extra bill. Thus, these effects could offset some of the coinsurance effects, but it is not at all certain. For the elderly beneficiary whose coinsurance for a service is *definitely* increasing, a *potential* decrease in extra-billing is small solace. AARP believes that specific constraints on extra-billing must be included to make sure that beneficiaries benefit through reduced extra-billing when payment rates (and coinsurance) increase, and do not have fee reductions shifted to them in the form of increased extra-billings.

In our testimony to the PPRC and our discussions with them, AARP has asked that the Commission develop beneficiary analyses as part of their review, for two reasons. First, we want to be sure that the Commission itself assesses beneficiary impact as part of its deliberations, much as it must of necessity consider the impact of various proposals on various specialties of physicians. Second, the beneficiary analyses can provide information for the Congress and others that is useful in making assessments and decisions about payment reform.

BENEFICIARY SIMULATION

The PPRC has developed a beneficiary simulation which will be included in their report to the Congress.

At this point, AARP appreciates the fact that the PPRC has made progress in assessing the beneficiary impact, but much of the analysis remains at relatively large "aggregate" levels. We need to look more precisely at the impact of specific payment changes on beneficiaries. Patients do not visit a physician in the "aggregate." I encounter specific medical problems and need to see specific doctors. What will be the impact on me and my neighbors, whose need for care may be quite different? For example, how will coinsurance and extra-billing change for an 80 year old woman living in a rural area who needs primary care services? What about a beneficiary living in an urban area, who requires surgical services?

Most of the PPRC models assume no change in billing or participation, assignment, volume and access. However, much of the underlying rationale for developing a revised payment system appears to be based on the assumption—and goal—that we want to change some of these behaviors. The change in payments now envisioned would appear to be based on an implicit assumption that fee increases *will* increase use and access to evaluation and management services, and to services in certain geographic areas, such as rural areas.

While, *on average,* beneficiaries will fare as well under the proposal as they do today, the reality is that some will do better and some worse, and AARP has recently asked the Commission to assess more precisely these effects. How many would be better off, and how many worse off? What are the characteristics of the "winners" and "losers"—for example, beneficiaries who are subject to higher or lower coinsurance as a result of the payment schedule changes, or beneficiaries whose access might be changed?

The Commission, AARP, and the Congress need to understand the characteristics of those beneficiaries who will see their cost-sharing increase or decrease because of reform proposals, and determine if provisions should be incorporated into the plan to minimize those effects. We urge the Subcommittee not to act until the Congress has a clear understanding of the implications for beneficiaries most affected by the plan. Further, we urge the Congress to implement any reform on a gradual, phased basis over a period of up to 5 years, in order to minimize abrupt changes in payments for either beneficiaries or providers.

Revised fee schedules such as those developed by the PPRC have unknown but vitally important implications for the volume of services provided by physicians, beneficiary access to specific types of services in specific geographic areas, and quality. Like extra-billing, the potential implications and physician responses are the subject of much speculation, but difficult to test empirically.

While it may not be important that we agree on simulation models which project what *might* happen in areas such as volume, access, and even extra billing, the policy process should be able to identify what we *want* to have happen—for those are presumably among the reasons that the payment rates are being changed. It would appear to us to be valuable to state explicitly certain goals in these areas—such as goals for increased volume and access for certain services, and in certain areas, and increased assignment rates or decreased extra billing amounts. No new system can guarantee achievement of all its goals immediately. Monitoring will be necessary to determine if the goals and assumptions on which the new system is based are in fact being met, and, if not, what further policy changes might be necessary.

We were pleased to see that the PPRC included a monitoring strategy in their recommendations. We urge the Congress to include and appropriately fund such a monitoring initiative as part of any payment reform that you develop. And, we ask that you go even farther, and set and define explicitly the goals and assumptions about volume, access and use, and beneficiary financial protection on which you are basing the revised system, and then use the monitoring system to assess whether those goals are being met.

BENEFICIARY FINANCIAL PROTECTIONS

AARP believes strongly that one objective of physician payment reform should be the creation of fair and rational fees. Once fair fees are achieved, extra-billing should no longer be permitted. AARP views balance billing limits and the continuation of the Participating Physician (PAR) program as transition steps to mandatory assignment.

The PPRC recommendations include some steps to provide financial protection for beneficiaries from the cost of extra-billing. AARP is generally supportive of the PPRC recommendations to set some upper limit on the amount of extra-billing on unassigned claims, so long as those limits enhance the financial protection afforded by the current MAAC limits. In addition, the AARP supports the PPRC recommendation to maintain the PAR program.

QUALIFIED MEDICARE BENEFICIARIES

We are very concerned about the PPRC recommendation for limiting mandatory assignment for "Qualified Medicare Beneficiaries" (QMBs). These are individuals with income below the federal poverty level identified under the recently enacted Medicare catastrophic coverage act. State Medicaid programs have to "buy" such individuals into Medicare coverage by paying their premiums, deductibles, and copayments, but do not have to provide Medicaid coverage for them.

As you know, Mr. Chairman, AARP has long opposed any effort to means- or income-test *benefits* under the Medicare program. Medicare has achieved a quarter century of success as a social insurance program for the elderly and disabled, with Medicaid the appropriate vehicle for means-tested health benefits.

AARP believes that any effort to means-test Medicare benefits would lead to the undermining of the social insurance foundation on which the program is built. Administratively, means-testing would be a nightmare, if not impossible. It is our understanding that when the Congress provided for the Medicare buy-in for the qualified Medicare beneficiaries, you did not consider them as eligible for Medicaid benefits, but rather as Medicare beneficiaries. AARP does believe that all classes of Medicaid beneficiaries should be treated alike for purposes of assignment. AARP would certainly support enhancements to Medicaid, but opposes any move to open the door to means-testing benefits under Medicare.

ASSIGNMENT WHEN THE BENEFICIARY HAS NO CHOICE OF PROVIDERS

Another assignment proposal by the Commission appears to be more promising. PPRC has endorsed the principle of mandatory assignment for services for which the beneficiary has no choice of provider. While the specifics of such a proposal need to be developed, it is a concept that AARP would be able to endorse. We would include hospital-based physicians' services, as well as other situations in which there is no choice of practitioner.

CLAIMS FORMS

Finally, we were very pleased to see that the PPRC included a recommendation that physicians submit claims for all beneficiaries directly to Medicare, which would greatly facilitate the administrative process for beneficiaries. We believe physicians should not be permitted to charge for filing claim forms, and that these PPRC recommendations are necessary steps for streamlining the program for beneficiaries.

It is important to note again that we believe that all of these beneficiary protection initiatives should be viewed in the context of our longer range goals in this area.

VOLUME ISSUES

AARP recognizes that a fee schedule alone will not address the continuing increases we see in the volume of Part B services. As I noted earlier, little is known about the impact of a revised fee schedule on volume.

PRACTICE GUIDELINES

One constructive step to address volume issues was outlined by the PPRC in their recommendation for enhanced research on medical outcomes and development and dissemination of practice guidelines. Such an approach can help assure that physician payment reform leads to longer-term redirection of medical services to the more effective modes of treatment. We support enhanced investments in these efforts as a means of stimulating the longer-range reforms desired.

EXPENDITURE TARGETS

A second approach to dealing with volume is through expenditure targets, and the PPRC has recommended moving to a national target based on volume of services per beneficiary.

While the framework of PPRC's proposal may be supportable and is certainly a more useful approach than other options studied by the commission, AARP has several fundamental questions about the implementation and impact of targets on our overall health care system.

- First, numerous questions arise about implementation of the concept. How are the targets computed, set, enforced, and responded to by the physician community? How would physicians in a community or a specialty assess their progress toward a volume target? What decisions might they make if volume is too high, or too low, compared with the target? How do they arrive at these decisions? Equally important, how does the individual physician respond? How do targeted volume reductions apply to an individual physician providing services to an individual patient?
- Second, it is vitally important to understand the implications of any reductions in access to services which might arise in response to a target. Volume reductions mean that visits, procedures, or tests are not performed. What specific services, in what areas, and for which patients, are reduced to meet a target?
- Third, what role will beneficiaries have in the setting, implementation, and response to a target. From the beneficiary perspective, if Medicare spending in my community is subject to some limits, I want to be represented in decisions about how the community will respond to those limits. Even with the best of intentions, the way the government and physician community may wish to respond to the targets may not be in the beneficiaries short- or long-term interests.
- Fourth, what will be the impact of expenditure targets on the overall health care system. Other countries which have such targets have national health insurance systems, while in this country we have multiple purchasers of care. How would Medicare expenditure targets effect the cost and access to care of the Medicare population and non-Medicare population? Would savings be shifted to the non-Medicare population, raising the price of their care? Such cost shifts would raise the cost of employee health benefits. As this Committee knows, the tax treatment of such benefit costs means that the cost-shift would result in increased tax expenditures for such benefits.

In the area of expenditure targets, as well as other elements of any reform plan, substantial transition periods as long as 5 years may be required to provide for informed implementation and to avoid abrubt changes.

AMERICAN COLLEGE OF SURGEONS PLAN

In addition to the PPRC proposal and variants of a resource based relative value scale, the Subcommittee is reviewing an alternative proposal which has been suggested by the American College of Surgeons (ACS). While AARP appreciates that fact that ACS has recognized the need for some moderation in the rate of increase in Medicare spending for physician services, we have a number of concerns with their plan.

AARP believes that any physician payment reform proposal should address all physician services—not be limited to specific specialties. Reform may apply different rules and standards to different services, but should be comprehensive in its approach. Thus, whether you decide on the PPRC proposal, the ACS approach, or some option to be developed, we urge you to apply payment reforms to all physicians services.

To address some of the specifics of the ACS proposal, AARP must first state our firm opposition to the ACS proposal to means-test assignment policy. As I noted earlier, AARP would support Medicaid expansions as the appropriate means for enhancing benefits for the low-income elderly and disabled, but will adamantly oppose any effort to means-test Medicare benefits, because means-testing undermines the foundation of social insurance on which the Medicare progam and Social Security Security are based.

The second assignment-related provision in the ACS proposal is mandatory assignment for surgical services when the beneficiary has no choice of providers. AARP regards this as a more promising initiative once the specifics are developed. In addition, we appreciate the fact that the surgical community is not advocating the concept of an "indemnity" fee schedule which is traditionally advocated by the physician community. As you know, Mr. Chairman, an "indemnity" schedule is the technical description used by the physician community to describe a fee schedule under which Medicare sets the fees but the physician is free to extra-bill the beneficiary whatever he or she can get away with.

AARP is also unsure about the effect of the ACS proposal to blend "demand" side factors with resource price factors in determining the relative value schedule. It is unclear to us how those factors would be defined and quantified.

Finally, we view the ACS volume initiatives in much the same way that we discussed for the PPRC proposal. We support the idea of developing practice guidelines, but are unsure how expenditure targets would be implemented. The ACS expenditure target proposal does, however, raise two policy issues that the Congress needs to consider carefully. First, if expenditure targets are to move beyond the national level, is it more appropriate to establish them at the specialty level (as suggested by ACS) or at a geographic level (as suggested by PPRC)? Second, if expenditure targets are to be established, is the type of phasing schedule advocated by ACS appropriate, with development of data and targets first, and the targets phased into the payment system in later years?

CONCLUSION

AARP continues to support the goals of physician payment reform, and ask you to consider seven key points as you develop your proposals.

First, we begin with the premise that the purpose of Medicare is to provide beneficiaries financial protection for access to needed health services. Payments to physicians are a means for achieving that objective. The Congress must evaluate its proposals against that objective.

Second, any change in payment rates such as those arising from an RBRVS, even if budget neutral in the aggregate, means that some beneficiaries would pay more in coinsurance for some important services or in some places—generally the very services an RBRVS proposes to encourage—and less for others. The Congress cannot ignore the fact that while a payment reform proposal may be budget neutral in the aggregate it will not likely be budget neutral for the individual beneficiary. Further information on the distribution and characteristics of the "winners" and "losers" is essential before action is taken.

Third, AARP recognizes volume as a key issue. However, no clear cut solution appears on the horizon. The Association believes it is necessary to pursue continuing research and development of practice guidelines. These guidelines, once established, should be incorporated into the payment system before expenditure targets are considered further. PPRC proposals for a national expenditure target requires greater elaboration but holds promise.

Fourth, monitoring volume, access to care and impact on beneficiaries is crucial to any reformed system, and might best be preceeded by explicit statements of Congressional goals in these areas. This information will be vital to see if the system achives the results intended, and to provide information that would be useful to refine the payment system over time.

Fifth, any changes in the payment system should be implemented in phases over a transition period of five or more years. That is important to minimize problems arising from sharp changes in beneficiary payments and providers fees. In addition, it would provide time to evaluate the impact of the initial changes and refine the system as we proceed.

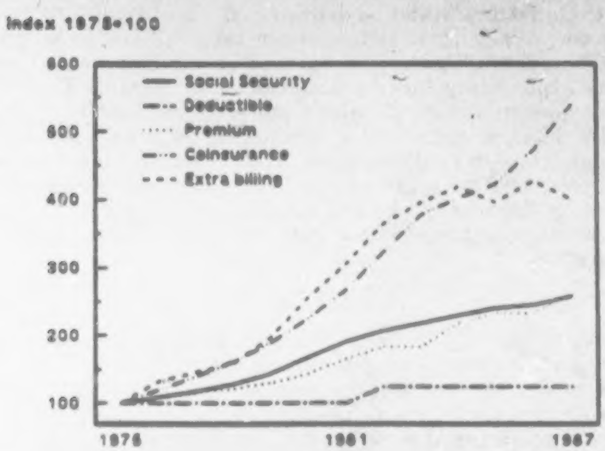
Sixth, the major out-of-pocket spending increases by beneficiaries now arise from the beneficiaries' significant contribution for deductibles, coinsurance, and premiums increases which stem directly from the escalating cost of Part B of Medicare. Assuming continuing and enhanced protections from extra billing we would want payment reform to provide a vehicle for reduction in the rate of increase in both government and beneficiary spending.

Finally we would urge the Congress to maintain the policy of assuring that payment changes be accompanied by beneficiary financial protection from extra billings. This includes mandatory assignment once fair fees are achieved through reform.

AARP thanks the Subcommittee for this opportunity to appear today to discuss this important issue, and I would be pleased to answer any questions that you may have.

Enclosure.

Figure 2-11. Social Security Benefits and Components of Medicare Part B Liability, 1975-87



Sources: Social Security Administration and HCFA Office of the Actuary.

FROM: Report of The Physician Payment Review Commission, 1988.

RESPONSES TO QUESTIONS SUBMITTED BY SENATOR PACKWOOD

Question. The AARP endorses having physicians bill Medicare directly. Direct billing by physicians is likely to increase the number of claims to Medicare, because some patients don't file their claims. This would increase the number of federal dollars paid in Part B. How do you propose we pay for these increased costs?

Answer. The Physician Payment Review Commission (PPRC) recommended this policy and estimates that it would "cost" $100 million to $150 million per year. This cost reflects the simple fact that beneficiaries would be getting the benefits that they are entitled to under the program but have not been receiving in the past due to the complexity of complying with the claim filing process. These claims could be submitted today and Medicare would be obligated to pay them. The PPRC notes that:

"Requiring physicians to submit all claims would increase outlays but the Commission regards this cost as necessary to assure that beneficiaries receive payments to which they are entitled."

AARP recognizes that physician payment reform including the cost of this provision, will be enacted in an environment which will require budget neutrality or even net savings. However, rather than identify which specific savings would offset which specific costs we believe that the entire reform package including the transition schedules and annual update factors will have to be devised within those budgetary constraints. We are prepared to support a reasonable package which accomplishes that objective.

Question. The AARP is lukewarm in its endorsement of the American College of Surgeon's proposal. What do you think are the major advantages and disadvantages for beneficiaries if Congress adopted a payment reform limited to surgical services?

Answer. AARP believes that any physician payment reform proposal should address *all* physician *services*—and not be limited to specific specialties. The payment system should be sensitive to the specific characteristics of different types of services but the system should be comprehensive in its approach.

We suggest reform for all physicians' services because we think the relationships among payments are irrational (e.g. some are far overpriced and others underpriced) and that cost increases in *all* areas are troublesome in their impact on beneficiary out-of-pocket costs and on government.

Question. The AARP does not endorse PPRC's recommendation for mandatory assignment for certain low income individuals. There is a successful voluntary program for low income people in Oregon called Medishare. Physicians agree to accept assignment for all patients who qualify for membership in Medishare which is based on their income level. This spares these patients from asking every doctor to take into account their financial status. Would you support this type of voluntary program?

Answer. AARP has supported the Participating Physician Program (PAR) under Medicare since its inception and believes that this program should be enhanced as part of any physician payment reform. AARP strongly opposes any means- or income-testing of Medicare *benefits* including assignment. AARP believes that any such effort would undermine the social insurance foundation on which Medicare is built.

Question. Some physician groups have argued against implementing expenditure targets on the grounds that they would represent implicit rationing of health care. What are AARP's views on this subject?

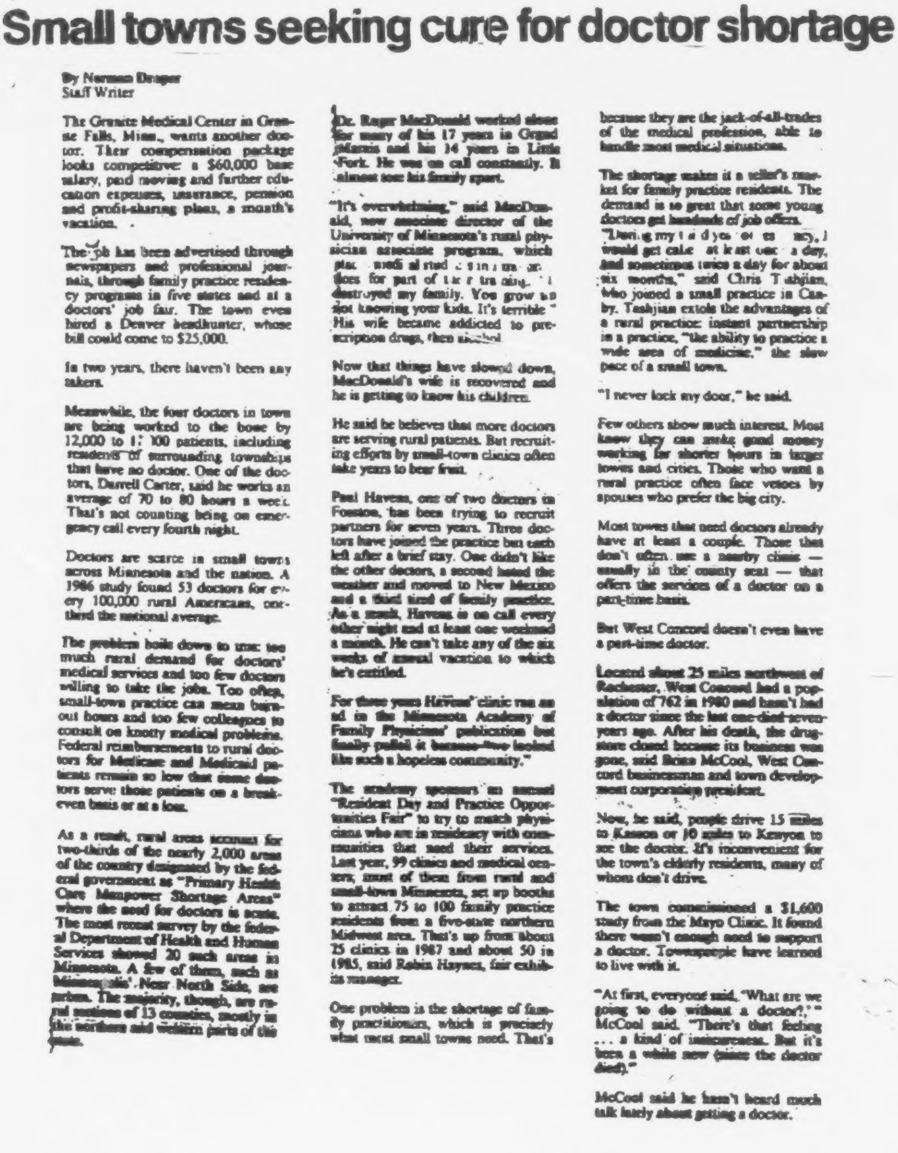
Answer. AARP raised a number of concerns with expenditure targets in our testimony to the Committee but believes that they, or some other form of volume constraint, may be necessary, with substantial transition periods, as a means of reaching the objective of constraining the rate of increase in spending.

Much of our concern arises from our opposition to any Medicare targets being assigned at subnational levels—States, medical specialties, or other groups. We do not believe that such entities are the appropriate decision-making forum for making Medicare policy decisions within some constrained expenditure total. Medicare is a *national* entitlement program and policy decisions about program expansions and constraints must be made federally. In addition, we are concerned with approaches which provide for undifferentiated payment constraints as the policy solution to volume increases.

However, if it is clear that any targets are set nationally based on the best available information; that policy responses are to be assessed and implemented by the federal government; and that those solutions will be designed to focus on *specific* volume and expenditure problems that are identified and not simply to ratchet down on overall spending and price levels, then it might be possible to proceed with a process similar to that in place under the Prospective Payment System for hospitals. We would be pleased to work with the Committee in developing such an approach.

SUBMITTED BY SENATOR DAVID DURENBERGER

(FROM THE STAR-TRIBUNE)



Small towns seeking cure for doctor shortage

By Norman Draper
Staff Writer

The Granite Medical Center in Granite Falls, Minn., wants another doctor. Their compensation package looks competitive: a $60,000 base salary, paid moving and further education expenses, insurance, pension and profit-sharing plans, a month's vacation.

The job has been advertised through newspapers and professional journals, through family practice residency programs in five states and at a doctors' job fair. The town even hired a Denver headhunter, whose bill could come to $25,000.

In two years, there haven't been any takers.

Meanwhile, the four doctors in town are being worked to the bone by 12,000 to 13,000 patients, including residents of surrounding townships that have no doctor. One of the doctors, Darrell Carter, said he works an average of 70 to 80 hours a week. That's not counting being on emergency call every fourth night.

Doctors are scarce in small towns across Minnesota and the nation. A 1986 study found 53 doctors for every 100,000 rural Americans, one-third the national average.

The problem boils down to this: too much rural demand for doctors' medical services and too few doctors willing to take the jobs. Too often, small-town practice can mean burn-out hours and too few colleagues to consult on knotty medical problems. Federal reimbursements to rural doctors for Medicare and Medicaid patients remain so low that some doctors serve those patients on a break-even basis or at a loss.

As a result, rural areas account for two-thirds of the nearly 2,000 areas of the country designated by the federal government as "Primary Health Care Manpower Shortage Areas" where the need for doctors is acute. The most recent survey by the federal Department of Health and Human Services showed 20 such areas in Minnesota. A few of them, such as Minneapolis' Near North Side, are urban. The majority, though, are rural sections of 13 counties, mostly in the northern and western parts of the state.

Dr. Roger MacDonald worked alone for many of his 17 years in Grand Marais and his 14 years in Little Fork. He was on call constantly. It almost tore his family apart.

"It's overwhelming," said MacDonald, now associate director of the University of Minnesota's rural physician associate program, which places medical students in rural practices for part of their training. "It destroyed my family. You grow up not knowing your kids. It's terrible." His wife became addicted to prescription drugs, then alcohol.

Now that things have slowed down, MacDonald's wife is recovered and he is getting to know his children.

He said he believes that more doctors are serving rural patients. But recruiting efforts by small-town clinics often take years to bear fruit.

Paul Havens, one of two doctors in Fosston, has been trying to recruit partners for seven years. Three doctors have joined the practice but each left after a brief stay. One didn't like the other doctors, a second hated the weather and moved to New Mexico and a third tired of family practice. As a result, Havens is on call every other night and at least one weekend a month. He can't take any of the six weeks of annual vacation to which he's entitled.

For three years Havens' clinic ran an ad in the Minnesota Academy of Family Physicians' publication but finally pulled it because we looked like such a hopeless community."

The academy sponsors an annual "Resident Day and Practice Opportunities Fair" to try to match physicians who are in residency with communities that need their services. Last year, 99 clinics and medical centers, most of them from rural and small-town Minnesota, set up booths to attract 75 to 100 family practice residents from a five-state northern Midwest area. That's up from about 25 clinics in 1987 and about 50 in 1985, said Robin Haynes, fair exhibits manager.

One problem is the shortage of family practitioners, which is precisely what most small towns need. That's because they are the jack-of-all-trades of the medical profession, able to handle most medical situations.

The shortage makes it a seller's market for family practice residents. The demand is so great that some young doctors get hundreds of job offers.

"During my third year of residency, I would get called at least once a day, and sometimes twice a day for about six months," said Chris Tashjian, who joined a small practice in Canby. Tashjian extols the advantages of a rural practice: instant partnership in a practice, "the ability to practice a wide area of medicine," the slow pace of a small town.

"I never lock my door," he said.

Few others show much interest. Most know they can make good money working far shorter hours in larger towns and cities. Those who want a rural practice often face vetoes by spouses who prefer the big city.

Most towns that need doctors already have at least a couple. Those that don't often use a nearby clinic — usually in the county seat — that offers the services of a doctor on a part-time basis.

But West Concord doesn't even have a part-time doctor.

Located about 25 miles northwest of Rochester, West Concord had a population of 762 in 1980 and hasn't had a doctor since the last one died seven years ago. After his death, the drugstore closed because its business was gone, said Brian McCool, West Concord businessman and town development corporation president.

Now, he said, people drive 15 miles to Kasson or 10 miles to Kenyon to see the doctor. It's inconvenient for the town's elderly residents, many of whom don't drive.

The town commissioned a $1,600 study from the Mayo Clinic. It found there wasn't enough need to support a doctor. Townspeople have learned to live with it.

"At first, everyone said, 'What are we going to do without a doctor?,'" McCool said. "There's that feeling ... a kind of insecureness. But it's been a while now (since the doctor died)."

McCool said he hasn't heard much talk lately about getting a doctor.

PREPARED STATEMENT OF JACEK FRANASZEK

Mr. Chairman and Members of the Subcommittee, I am Jacek Franaszek, M.D., F.A.C.E.P., a practicing emergency physician in Hinsdale, Illinois, and President of the American College of Emergency Physicians (ACEP). I appear today on behalf of the more than 12,000 members of ACEP. I am accompanied by Thomas Nickels, Director of the College's Washington, D.C. office. The College appreciates this opportunity to comment on various aspects of the upcoming annual report to Congress from the Physician Payment Review Commission (PPRC)

RELATIVE VALUES AND A MEDICARE FEE SCHEDULE

Mr. Chairman, emergency medicine was not among the 18 specialties included in the first phase of the Harvard Resource-Based Relative Value Scale (RBRVS) study completed last fall. However, emergency medicine is among the specialties that are now being examined in the second phase of the project. Overall, ACEP believes that the Harvard RBRVS project represents a major contribution to the development of a relative value scale for physicians' services that more accurately reflects the actual inputs needed to produce such services.

We further believe that the Physician Payment Review Commission has proposed some important modifications to the Harvard methodology that make it feasible to use a resource-based relative value approach to Medicare payments for physicians' services. On the basis of these modifications, the PPRC has recommended that Medicare's current usual, customary and prevailing payment system for physicians' services be replaced with a fee schedule that is based primarily on resource costs. ACEP supports this recommendation. The work at Harvard and the research by the Commission clearly show that physician evaluation and management services are systematically undervalued when compared with most other physicians' services provided to patients. Most of our activities consist of these kinds of services. This finding is of particular interest to emergency physicians who have the responsibility to react quickly and decisively in assessing and dealing with the serious nature of medical problems treated in the emergency department. In effect, patient evaluation and management at these critical moments are what encompasses the practice of emergency medicine.

While resource costs have received most of the attention in discussions about ways to establish a more rational and equitable Medicare payment system, the importance of some services relative to other services has been recognized by Congress in an additional way. Based on recommendations from the Commission, changes have been enacted to redress some of the current payment imbalances for primary care services, including emergency department visit services. The issue of special recognition for primary care services at present arises because more time will be needed before a new Medicare payment system based on resource costs can be implemented. We hope this Subcommittee will continue to recommend differential treatment for primary care services, including emergency department visits, in connection with any payment actions taken by Congress on an interim basis.

FEE SCHEDULE IMPLEMENTATION

We have some concerns, Mr. Chairman, about the PPRC's recommendations to move rapidly with implementation of a Medicare fee schedule in 1990 leading to full implementation by 1992. It seems to us that there is still much more to be learned before major revisions in payment rules are adopted by law. We recognize, of course, that the Congress is anxious to approve a better approach to physician payment than now exists. However, the impact on both beneficiaries and physicians of some of the proposed changes recommended by the Commission, is not very clear at this time, but could be significant. Our own specialty participation in the Harvard study, for example, is only just beginning, and more time may be needed to develop the data and analysis needed for all specialties before a workable fee schedule can be adopted. It is also essential that changes of the magnitude proposed be based on information—in addition to relative value calculations—that is both accurate and current, especially in the case of physician cost of practice data. We urge that Congress be mindful of these considerations in judging the appropriate timing of physician payment reform initiatives.]

DEFINING PHYSICIANS' SERVICES

Mr. Chairman, the Commission has concluded that reforms in the coding and definition of physicians' services are needed in order to implement a fee schedule based on resource costs. One of these reforms involves improvements in the current codes used for evaluation and management services—commonly referred to as the visit codes. Results from the Harvard study suggest that there are problems with the current codes used by physicians to accurately reflect their work effort because the levels of service are not precisely defined. Interpretations of the visit codes varies widely, not only by specialty and geographic location, but also among individual physicians.

ACEP agrees with the PPRC that there are serious problems with the use of the current codes in defining physician work, and that there are particular problems with some of the codes for emergency department visits. We also agree with the Commission that the ambiguity inherent in the current codes could create serious problems with valuing and paying for services in a fee schedule. As we understand it, however, the Commission is now recommending that the coding system be revised so that time would be used as a significant factor in establishing different levels of service and, presumably, therefore, different relative values for these services, as well. Such a recommendation may be appropriate for some physician 'specialties, but we believe there is a unique difficulty with linking the valuation of emergency services to time. Many emergency services and procedures need to be provided quickly, and their value lies in their quick application. Often, the longer it takes to provide a service in an emergency, the lower the value to the patient.

ACEP believes that the value of emergency department visit services should be more closely linked to such factors as knowledge, skill, effort and stress, and not disproportionately to time. We have communicated our views about the special problem of using the time factor in emergency settings to the staff of the Commission and to Harvard researchers looking at the services provided by specialists in emergency medicine. The College has also recently completed its own review of coding issues involving emergency department services, and intends to share its recommendations with the PPRC and with officials of the Health Care Financing Administration as soon as possible.

TARGET EXPENDITURES

Mr. Chairman, one of the major recommendations from the PPRC calls for approval of a national target expenditure plan for physicians' services under Medicare. More specifically, the Commission recommends beginning with a single target at the national level, but anticipates that the policy could evolve into one with multiple geographic or specialty-specific expenditure targets.

ACEP opposes this recommendation in its current form for a number of reasons, but primarily because it fails to recognize the nature of the demand for emergency services by the Medicare population. Among other things, the theory behind a target expenditure plan is to establish incentives to limit expenditures for physicians' services that take into account both the volume and the price of the services provided. Emergency physicians, however, do not determine, nor can they control, the number of patients who present to emergency departments of hospitals. Moreover, from a public policy standpoint, ACEP strongly opposes any steps that would tend to discourage any patients from seeking needed emergency care when they are acutely ill or believe they need urgent medical attention.

Thus, the idea of establishing an expenditure target for emergency services—as part of an overall scheme or under a multiple target plan—could be problematic. For one thing, we do not see how such expenditures could be reasonably predicted in advance. If, however, Congress decides to adopt an expenditure target plan, Congress should direct that emergency services be excluded from the plan.

MEDICARE ASSIGNMENT

Finally, Mr. Chairman, I would like to share the College's views about the need for improvements in Medicare's assignment procedures. We believe that major payment reform changes should not be undertaken without careful consideration of the financial implications of those changes on patients.

Mr. Chairman, ACEP is pleased to note, following a detailed examination of Medicare Part B claims data, that emergency physicians appear to have the highest assignment rates of all physicians who provide services to patients under the Medicare program. For example, our study of Medicare data on emergency department visit codes shows that assignment is taken on about 90 percent of all claims. There may be several reasons why the assignment rate is not even higher than this, the most important of which has to do with the unreasonably low amounts paid by some Medicare carriers for patient management and evaluation services in general, and for emergency physicians' services in particular.

We understand that the Commission has, in principle, endorsed the need for making changes in Medicare's assignment policy where beneficiaries have no meaningful choice of provider, including in emergency circumstances. We would also point out, however, that unlike other practitioners, emergency physicians have no choice in the selection of which patients they will treat. In fact, it has long been the position of the College that no patient coming to the emergency department should be denied emergency medical care. I would further add that Federal law also requires that all patients be examined and treated as if they have potentially life-threatening or other serious illnesses or injuries. In other words, we believe we have an ethical, moral, and legal responsibility to evaluate, and where needed, to treat all patients presenting to the emergency department.

Since patients who present with emergencies have no meaningful choice of provider, and, since the emergency physicians who treat them really have no choice in the selection of which patients they will treat, we agree that Medicare's current assignment rules should be changed under a new Medicare fee schedule. And if, as part of this reform process, payments for emergency physician services are reasonably valued and paid appropriately, the American College of Emergency Physicians is prepared to support the acceptance of such payment levels as payment in full—thereby relieving Medicare patients of balance billing obligations. We intend to meet with the Commission to explore this matter further.

Thank you, Mr. Chairman, for this opportunity to testify. I would be pleased to answer any questions you or your colleagues may have.

Prepared Statement of Robert Graham

I am Robert Graham, M.D., Executive Vice president of the American Academy of Family physicians, the national medical specialty organization representing over 65,000 practicing family physicians, residents in training and medical students. On behalf of our members and their patients, I am delighted to again before this subcommittee to discuss with you Medicare physician payment reform with a fee schedule based on resource costs.

The members of this subcommittee are well aware of and sensitive to the problems in the current Medicare system. The "CPR" payment methodology is widely acknowledged to be highly inflationary, complex, unpredictable, inequitable, and fraught with perverse financial incentives. Medicare expenditures have experienced unrelenting growth, yet access to many important services remains a problem.

Family Physicians have appeared before the Senate Finance Committee on several occasions to state the many concerns of the American Academy of Family Physicians with the Medicare system. We have shared with you the difficulties experienced by communities with limited access to primary care services and by family physicians discouraged by an inequitable reimbursement system that undervalues many important medical services. You have heard this message from many distinguished witnesses, including Professor William Hsiao of Harvard. Today I appear before you to encourage you to enact a solution to many of these problems using the Harvard resource-based relative value scale (RBRVS) as the cornerstone of that solution.

RESOURCE BASE FEE SCHEDULE

The American Academy of Family Physicians believes that a Medicare physician fee schedule based on the Harvard RBRVS offers greater potential to achieve meaningful physician reimbursement reform than anything that has been proposed in many years. We believe that such reform will benefit our patients by restoring a proper emphasis on primary care and encouraging the provision of disease prevention and health promotion services. Furthermore, we project that badly needed long-term improvements in access to primary care and prevention services will result from encouraging physicians to enter primary care specialties.

By estimating the resource costs of providing physician services, the RBRVS provides an approximation of the relative prices that would be achieved if it were possible to deliver physician services in a competitive market. In achieving this result we believe the RBRVS provides a framework for grounding Medicare physician payment squarely in the American economic tradition.

The Harvard RBRVS study has now been thoroughly reviewed by health services researchers, economists, and representatives of beneficiary groups, government, business and labor, and medicine. For the most part the study's results have been judged valid and reliable. Some methodological shortcomings have been identified and are being addressed by the Harvard team and/or PPRC in a timely manner. We specifically congratulate PPRC for its excellent work to refine the fee schedule, and to develop reasonable approaches to policy issues surrounding implementation of a Medicare fee schedule. In particular, we are pleased with PPRC's conclusion that "when a service provided by physicians in different specialties is essentially the same, the payment should be the same." Furthermore, the Academy supports incorporation of time into the description of visit codes, to promote more accurate use of codes for these evaluation and management services. We believe that a resource-based Medicare fee schedule as developed by Dr. Hsiao and his team and as modified by PPRC is sufficiently developed to allow Congress to move in an expeditious manner to reform Medicare physician payment.

The results of the RBRVS study suggest that current payments for many physician services are severely out of balance in relation to the resource costs of providing those services. A resource-based fee schedule would revaluate physician services in a manner favorable to primary care and rural areas. The redistributive impact of adopting a resource-based fee schedule would be consistent with previous Congressional actions providing higher MEI updates for primary care services and underserved areas, placing floors under the prevailing charges for primary care services, and selectively cutting the prevailing fees of some high-volume, overpriced procedures.

As you know, there is a significant and persistent shortfall in the supply of primary care and rural physicians relative to the need for their services. The United States has a smaller proportion of primary care physicians than any other developed country (13 percent of U.S. physicians are family physicians as compared to 53 percent general/family physicians in Canada). Inadequate reimbursement has proved to be a major disincentive for physicians to choose these types of practice and has resulted in severe access problems for some Medicare beneficiaries. By correcting the existing inequities in Medicare physician payment, an RBRVS-based fee schedule will, in the long run, encourage more physicians to choose primary care specialties and rural practice locations.

Recent PPRC simulations of the redistributive impact of a resource-based fee schedule suggest that the Medicare income of family physicians will on average increase by 30 to 40 percent. This is considerably less than the 65 to 70 percent increase projected by the Harvard team last Fall. It is important to recognize that, on average, approximately 10 percent of family physicians' income is derived from the Medicare program. Furthermore, family physicians typically provide a broad range of services, some of which will undergo a fee reduction under a resource-based fee schedule.

Geographic Multiplier

The PPRC recommends that the Medicare fee schedule by modified with a geographic multiplier that is intended to reflect geographic differences in the cost of practice. While we recognize that PPRC's recommendation for a geographic multiplier would eliminate much of the existing geographic differential in Medicare prevailing charge screens, it is our position that there should be no differentiation in physician fees based on practice location. This payment policy is grounded in the belief that equivalent service should result in equivalent compensation.

The urban/rural differential in current Medicare prevailing fees has compromised beneficiaries' access to medical care. Lower fees have discouraged physicians from locating and maintaining their practices in rural areas. Furthermore, low approved charges affect physicians' willingness to accept assignment for Medicare claims and result in higher relative out-of-pocket expenses for rural beneficiaries.

Imposing a geographic multiplier on a Medicare fee schedule lacks merit on three counts. First, it is inconsistent with federal policies that incorporate uniform national rates, such as federal income tax, social security payments, and the Medicare Part B premiums. Second, no systematic, significant, and reliable differences in the cost of urban and rural practices have been demonstrated. The cost-of-practice index proposed by PPRC is based on proxy measures of the prices faced by physicians in running their practices and yields results that are in marked contrast to surveys that have directly measured physicians' costs of practice.

Furthermore, the index incorrectly assumes that the costs of medical equipment, repairs, and transportation do not vary geographically, and it fails to consider the unavoidable necessity of maintaining a larger standby capacity in rural practices. Third, there are non-quantifiable cost of rural practice, such as being on call virtually at all times, that obviate any rationale for higher reimbursement rates in urban areas.

Congress would be well advised to approach the creation of a geographic multiplier with caution. The consequences of having made ungrounded assumptions about geographic differences in the costs facing hospitals certainly are not lost on this committee. Because of its redistributive impact, the political cost of attempting to undo a geographic multiplier for physician services could be substantial.

Updating the fee schedule

The Academy believes that the Physician Payment Review Commission will continue to have an important role under a reimbursement system with a resource-based fee schedule. Specifically, the Academy recommends that PPRC have a defined role in working with the American Medical Association and individual medical specialty societies in annually updating the Medicare fee schedule. The process should include frequent and regular monitoring of practice costs, and updating to reflect changes in practice costs which are anticipated because of potential changes in Medicare reimbursement for some services.

FINANCIAL PROTECTION OF MEDICARE BENEFICIARIES

Family physicians understand the financial burden that health care can place on Medicare beneficiaries. Patients make known their fears about rising health care costs and share their uncertainty about Medicare payment policies. The Academy believes that any new Medicare reimbursement system should be fair to beneficiaries.

Simulations by the Physician Payment Review Commission suggest that, on average, out-of-pocket expenses for beneficiaries will decrease under a resource-based Medicare physician fee schedule. However, hidden in these highly aggregated averages is the potential for some beneficiaries to experience significantly increased expenses. For this reason the Academy supports measures to protect beneficiaries both during the transition to and after the implementation of a fee schedule.

During the proposed transition to a fee schedule we anticipate that prevailing charges will move toward the projected fee schedule amounts. As these modifications are made, it is imperative that Medicare beneficiaries be protected from excessive balance billing for those services for which the fee is reduced. This can be accomplished by limiting the total amount which physicians can charge to a specific percentage of the prevailing charge, such as 125 percent. This strategy has been utilized by Congress in implementing limits on "over priced" services and therefore would be consistent with current policy.

The Academy supports two strategies for protecting beneficiaries after the fee schedule is in place. This first proposal is aimed at protecting the most financially vulnerable elderly. Assignment should be required for all services provided to Medicare beneficiaries whose income is below two times the poverty level. This proposal goes somewhat beyond the PPRC proposal that calls for assignment for services provided to "qualified Medicare beneficiaries" covered by Medicaid.

The second strategy is to limit balance billing by all physicians for all services to Medicare beneficiaries not covered by the above proposal to 125 percent of the fee schedule amount. These limits would replace the current Maximum Allowable Actual Charge (MAAC) limits. The Academy believes that limiting balance billing to 125 percent of the fee schedule is an equitable balance of the interests of beneficiaries and physicians.

For reasons noted in our comments below on expenditure targets, the Academy's support of these beneficiary protection provisions is contingent on the understanding that there will be annual aggregate fee schedule updates which fully account for legitimate increases in the cost of practice, increased number of beneficiaries, the aging of that population and technological advances. The balance of interests must continue to be equitable for the program to remain viable.

EXPENDITURE TARGETS

The Physician Payment Review Commission has recommended utilizing expenditure targets as an integral part of an overall strategy for moderating the growth in volume of physician services through a reduction in unnecessary and inappropriate services. The AAFP believes that the Medicare fee schedule may help reduce inappropriate increases in the volume of services by correcting incentives for overuse in the current payment system. We understand, however, that a fee schedule alone may not fully address these problems.

The Academy believes that a decision to utilize expenditure targets as a means of moderating increases in Part B expenditures represents an explicit decision to ration services to Medicare beneficiaries. It is a change from the perception of current policy, which is that unlimited resources are available to meet beneficiaries' needs.

An expenditure target that caps physician expenditures in the aggregate would not automatically distinguish between limits on effective or ineffective services nor between appropriate or inappropriate services. We have concern therefore, that an expenditure target scheme unless targeted to specific classes or categories of "overused or overpriced" services could have the untoward effect of markedly decreasing access to basic, day to day services.

A recent examination of Medicare claims data for calendar years 1983 through 1986 demonstrates a very uneven pattern of growth in the volume of services. While the per beneficiary volume of primary care services (such as office visits) has increased little, if at all, volume has increased rapidly for surgical and diagnostic procedures. Three kinds of service grew at above average rates: surgery, radiology, and specialized diagnostic tests such as electrocardiograms, cardiac stress tests, and echocardiography. Together these three types of service account for two-thirds of the increased spending. In sharp contrast to the increases in surgery, radiology, and diagnostic tests, total number of office and hospital visits per beneficiary changed very little. If Congress decides that the only feasible way to control costs is through expenditure targets, the Academy proposes that the targets be implemented in an way that minimizes the impact on access to primary care services, by ensuring the appropriate distribution of limited resources. Further, if congress believes that it should proceed with this strategy, the Academy would propose that separate expenditure targets should be established for specific services or categories of services that have a high cost and high volume profile and for which there is a large element of physician discretion.

There continues to be a need for improved beneficiary access to primary care services. Congress in previous years has recognized the need and has taken specific action to encourage provision of these services (higher MEI updates for primary care services and for underserved areas, and a floor under the prevailing charges for primary care services). Conversely, Congress has adopted cuts in the prevailing fees for some high-volume, over-priced procedures. We believe that Congress should once again look at the public policy objectives of improving access to primary care services and take this into account when considering an expenditure target approach to limit Medicare spending.

We are concerned that present liability climate could undo the intended effect of various efforts to reduce the volume of minimally beneficial services. Under the existing civil justice system, if a patient is harmed as a result of withholding a service that has any probability of benefit, no mater how small, it is difficult to defend that decision in court. The fear of incurring a liability action and the incentives posed by expenditure targets influence decisions about rendering services of minimal potential benefit in opposite directions.

While expenditure targets provide a financial incentive for reducing volume, they do not automatically provide a mechanism to decrease inappropriate and unnecessary services. It is unclear at this time how the medical profession can collectively control utilization in order to meet the targets. At this point there are serious questions about how an expenditure target approach would be implemented and its impact on the health care system. In no case should expenditure targets be applied until the resource-based Medicare fee schedule is fully in place. The effects of the targets could then be carefully monitored.

During the transition to the fee schedule, practice guidelines should be developed and made available to the medical community to assist in identification of unnecessary and inappropriate services. The Academy is highly supportive of effectiveness research and believes that this information can assist physicians in this increasingly complex medical climate to understand the most efficacious ways to practice medicine. The Academy already is working to establish clinical policies for family practice in concert with Dr. David Eddy at Duke University. We believe that practicing physicians will be able to use this information to provide optimal medical care to their patients.

SUMMARY

The message that I would wish to leave with you today is a positive one, one of hope. Congress is presented with a unique opportunity to enact meaningful reform of Medicare physician payment this year. The excellent work of Dr. Hsiao and his team and of the Physician Payment Review Commission provide a firm base on which to rationally restructure Medicare. A resource-based fee schedule would create a level playing field for physicians, provide for a health care system that is more balanced in terms of the specialty and geographic distribution of physicians, moderate the growth in Medicare expenditures, and, most importantly, ensure much improved access of beneficiaries to appropriate medical services. The American Academy of Family Physicians urges you to enact Medicare physician payment reform this year.

PREPARED STATEMENT OF SENATOR ORRIN G. HATCH

Mr. Chairman, I am pleased to have this opportunity to testify before the Subcommittee on Medicare and Long Term Care regarding physician payment reform. Specifically, I believe that we have a geographic inequity that is harming both the provider and the patient in my home state of Utah.

The current Medicare reimbursement system for physicians has evolved over a number of years and has arrived at a place that no one was really trying to reach. We now have a reimbursement system in which physicians providing exactly the *same service* are reimbursed at very different levels depending on whether the office is on one side of a state line or the other.

As you can see from this chart of the physician reimbursement rates in Utah and our neighbor states, physicians in neighboring states receive up to 20 percent more for services provided in the office than do physicians practicing in Utah. For physicians providing hospital care, this discrepancy can be as high as 33 percent.

I know that members of this committee will carefully consider the information and recommendations provided by the Physician Payment Review Commission (PPRC). The Commission recently completed a study of geographic variations in Medicare charges and reported their findings to Congress in March 1988. This report states that prevailing charges may vary extensively from one locality to another and confirms that payments to Utah physicians are below payment rates in other states. Mr. Chairman, I would ask that this table of the these findings be included in the record. This table shows that all of the Utah prevailing charges are below the national mean. In addition, prevailing charges in Utah for some of the services compared are near the bottom of all charges in the United States.

The PPR Commission looked at factors that could explain and justify these geographic differences and concluded that the cost of practice differences accounted for some of the variation, but certainly not all. This conclusion is further supported by a study completed by the Utah Medical Association which indicated that the actual costs of practice, including such items as malpractice insurance, employee expenses, office rent, and supplies are not substantially lower in Utah. In many cases, the costs are actually higher in Utah than in the surrounding states.

Unfortunately, when our current reimbursement mechanism was created over fifteen years ago, it highlighted the differences in practice costs between states. In addition, these state differentials were frozen at those 1973 levels, because the law limited percentage increases in out-years and applied this limitation to all states equally. Thus, over time, arithmetic increases in payments have been considerably greater in those states which started with a higher base, compounding the problem with each passing year. States like Utah, which had low fee structures in 1973, have been penalized ever since for their conservative charges. We are punishing those physicians who were cost conscious in delivering services.

I am concerned about this system of inequity in Medicare physician reimbursement, Mr. Chairman, but I am more concerned about what these inequities are doing to the quality of health care in Utah and other under-reimbursed states. In the same report, the PPR Commission went on to state that "the wide variation in charges unrelated to differences in cost of practice could mean access to care and beneficiary financial protection might be compromised in areas where prevailing charges are low. This is happening in Utah right now, Mr. Chairman. I have been told that physicians practicing in Utah are moving their practices to neighboring states with higher reimbursement rates and I fear that young physicians may decide to avoid practicing in Utah all together. If this trend continues many seniors in Utah may have difficulty finding a doctor when they need one. Compounding this trend, more and more physicians who remain in Utah are reluctant to accept assignment of Medicare patients. Can you really blame them when physicians with similar practice costs across the state line are receiving 20 to 30 percent more for exactly the same services? In turn, because there are fewer participating Medicare physicians in Utah, our elderly are faced with higher out-of-pocket costs for their health care.

When this pressure on primary care providers and their patients is coupled with the reimbursement pressures that are forcing many rural hospitals to close their doors, I think the future of access to health care in Utah may be in jeopardy—and I intend to do everything in my power to stop this. I want to work with you to ensure that our federal laws do not continue to wreck havoc in our health care delivery system.

In addition to reducing access to health care, inequitable state reimbursement rates often place unfair burdens on the non-Medicare patients of these providers. Physicians who do remain in Utah—and are reimbursed below costs—face no alternative but to increase their charges to other payors.

At the same time, Utah Medicare beneficiaries are subsidizing beneficiaries in wealthier states. All Americans, regardless of their residence, are subject to the same federal tax and Social Security liability; all Medicare enrollees pay the same premiums for Part B coverage. Yet, there is not an equal distribution to the providers serving these seniors. Taxpayers in some parts of the country, like Utah, are subsidizing citizens living elsewhere. Ironically, in the case of Medicare, more prosperous sections of the country tend to be subsidized by less prosperous ones.

Mr. Chairman, I am firmly committed to eliminating the inequities in Medicare physician reimbursement rates. When the Senate reconvenes in early May, Senator Garn and I will be introducing a resolution expressing the sense of the Senate that the problem of geographical variations must be addressed and that the present inequities be eliminated in any mechanism for Medicare physician reimbursement. I urge you and your colleagues to co-sponsor this resolution. The entire Utah delegation urges you to carefully consider this issue in your deliberations on physician payment reform.

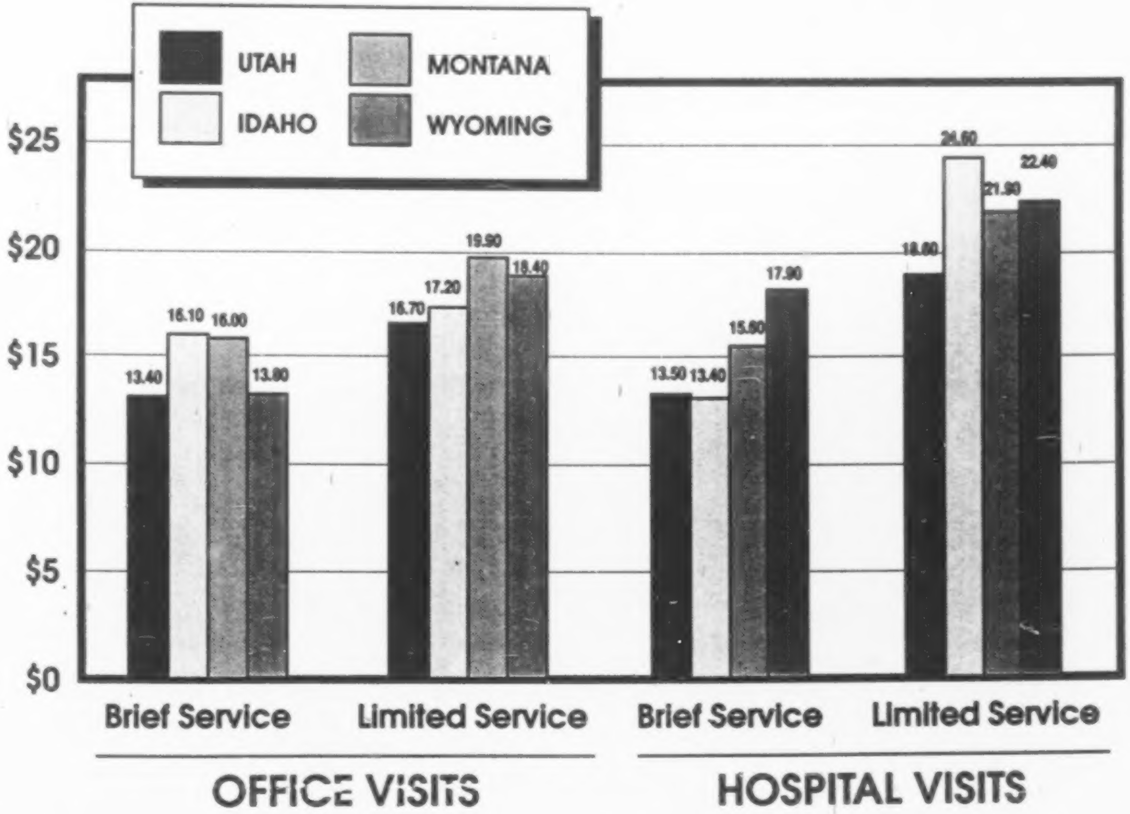
I appreciate this opportunity to testify this afternoon, Mr. Chairman. I know that this committee faces a monumental task in physician payment reform. There are many possible solutions to this pressing problem, such as allowing those states who have been harmed by under-reimbursement to rise above the cap and receive a greater annual increase than other states. This approach would allocate a disproportionate share of any increase in physician payments to those states with the lowest rates. We may also want to consider a national rate for physician reimbursement, or a plan that would re-calibrate state reimbursement rates based on today's practice costs.

I am anxious to help this committee in any way possible to identify an appropriate solution to this critical problem. These geographical inequities must be eliminated if we are to protect the availability of quality health care in America.

Distribution of Prevailing Charges for Selected Procedures and Specialties, Compared with Prevailing Charges in Utah, 1987

Procedure Name	Specialty	Mean (dollars)	PERCENTILES 5th	50th	95th	Utah	Approx. Utah Percentile
Office Visit Comprehensive	Internal Medicine	81	55	78	111	77	48th
Hospital Care	Internal Medicine	91	55	89	124	82	34th
EKG Complete	Internal Medicine	38	30	39	45	33	25th
Upper GI Endoscopy	Gastro-enterology	343	254	330	542	253	4th
Total Hip Replacement	Orthopedic Surgery	2694	1923	2662	3549	2079	15th
Coronary Artery Bypass	Thoracic Surgery	4385	3092	4434	5919	3734	27th
Gallbladder Removal	General Surgery	922	721	887	1350	737	11th
Prostatectomy (TUR)	Urology	1270	887	1109	1774	887	5th
Cataract Removal	Ophthal-mology	1689	1390	1624	2122	1368	3rd

Physician Reimbursement Rates



PREPARED STATEMENT OF SENATOR JOHN HEINZ

This morning's hearing, Mr. Chairman, opens a critical if not dramatic new chapter in the history of the Medicare program. Today, we will receive recommendations on whether and how the Congress should proceed toward a major restructuring of Medicare's approach to physician reimbursement. I commend you, Mr. Chairman, for convening this hearing as a first step in our drafting of this new chapter.

I find it both of historic interest and of value on policy grounds to note that today's hearing comes nearly six years to the day after the Congress passed it's last major Medicare payment reform package—prospective reimbursement for hospitals—as part of the Social Security Amendments of 1983. For many of us, this serves as a reminder of the success we have had in restraining hospital costs. It it also a reminder of the unintended, negative consequences of DRGs for patients who found themselves being released "quicker and sicker" out of hospital back doors in the early phases of DRGs, and of the numbers of hospitals now having to close their doors entirely after years of belt-tightening. Last year alone we saw 81 hospitals close—including two in my own state.

I hope that we will draw from our historical text on hospital payment reform as we open the chapter on physicians. In my mind, one of the most basic lessons we can take away is that the payment reforms we design must be equitable as well as responsive to cost concerns, and also accompanied by reforms to protect the beneficiary's access to high quality medical care.

What I hope to learn, therefore, from the witnesses today are their views first, on how we should restructure physician payment and second, how we should proceed with this restructuring in light of other efforts to improve the effectiveness and control the cost of physician services. Two weeks ago, this Committee heard testimony on the financial hardship of hospitals after four years of sustained cost containment pressure, while physician expenditures has risen 16% a year. We were also told that any effort to control rising Part B costs will require a mix of reforms to restore equity in physician payments, control overall spending, improve the effectiveness of medical practice, and protect the very personal relationship of a patient and his or her physician as well as their access to quality care.

This is a tall order requiring long-term solutions. Unfortunately, we do not have the luxury of time. Whether we are looking at the President's $5 billion savings target for Medicare or something less, we face difficult budgetary decisions this year that hopefully can be made in support of our goal of creating an equitable and affordable system of physician payment. We are fortunate, Mr. Chairman, to have two witnesses before us today—nationally regarded for their expertise in physician research and policy—to offer some insight on how the Congress can proceed with sound physician reimbursement policy the midst of this tough, budgetary environment. I look forward to their testimony.

PREPARED STATEMENT OF WILLIAM C. HSIAO

REASONS FOR THE STUDY

Physician payment reform has propelled itself into a major health policy issue in recent years. The major reason is rising physician expenditures, which have been growing at two or three times the rate of increase in the consumer price index (see Graph A attached), and which are expected to continue for the foreseeable future. Growth in Medicare physician expenditure has led the way. Between 1975 and 1986, expenditures per enrollee grew by about 15 percent per year; about 48 percent of this growth was due to price increases and about 52 percent due to increases in numbers of billed services per enrollee.

While we are spending more of our gross national product for medical services, studies also have found that many frequently-performed procedures and tests are inappropriate or highly questionable (see Graph B attached). In other words, a significant number of the procedures and tests are unnecessary and inflict pain, suffering, and risk patients' lives while consuming our scarce health resources.

These worrisome experiences prompted the U.S. Congress to establish a Physician Payment Review Commission (PPRC) in the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985. The PPRC is to advise the Congress and Administration on alternative approaches to reform the Medicare physician payment system.

Medicare pays physicians based on their charges. These charges are likely to be distorted, however. Three reasons are frequently cited as causes for distorted fees. The first is insurance. It makes both patients and physicians less sensitive to price and hence any services covered by insurance tends to raise the price of these services. However, insurance created uneven distortions across physician services. Private insurance plans have historically covered surgery, radiology, and other diagnostic tests but did not cover medical services such as office and hospital visits, consultations, and comprehensive examinations. Hence, insurance raised the price of some services but not others.

The second reason is that often new surgical procedures and high-technology tests are extremely complex and difficult to perform when introduced, and, as a result, fees are justifiably set very high. But, as time passes, with better training, clinical experience, and technological improvements, these procedures and tests become easier to perform. The current payment system, however, does not provide any market or administrative pressure to induce the lowering of these fees as their costs decline.

Lastly, some surgical procedures are performed on vital parts of the human organs such as the heart, brain, and eyes. Under fear and anxiety, patients are unable to make rational choices about what they should pay; patients often are willing to pay whatever physicians want to charge. Therefore, these fees are not restrained by normal market competition.

For these and other reasons, fees charged for many physician services are distorted. There is wide agreement among physicians that the current fees are unfair and inequitable, and in need of fundamental reform. Both the American Medical Association and the American College of Surgeons have recommended that Medicare payments should be based, partially or entirely, on the resource-based relative values.

Why should the Congress care about distortions in fees? The reason is simple. Distorted fees offer perverse incentives to the physicians. A distorted incentive structure could have serious effects on what services are provided by physicians, the quality of these services, time and effort spent by the physician with the patient, and choice of specialty by new medical school graduates. Doctors may receive very generous payment for some services while receive little for others. For example, the Medicare payments for some office visits hardly cover the doctor's overhead cost while the payments for many tests are highly lucrative. This distorted economic structure may influence physicians' decisions on what tests should be performed and what treatment should be given. With more generous compensation given to the high-technology tests and surgical procedures over primary care services, the current payment system may very well contribute to the steady inflation of medical costs and the decline in primary care services.

Congress recognized the need to reform the incentive structure for physicians in order to control health care costs and improve quality. In the 1985 COBRA legislation, Congress mandated a study for the development of a resource-based relative value scale as a possible alternative method for Medicare payment to physicians. The Health Care Financing Administration asked for competitive research proposals. My colleagues and I at the Harvard School of Public Health submitted a proposal and were awarded a grant to conduct the study.

METHOD

The RBRVS study aims to develop a resource-cost-based relative value scale by investigating the resource-input costs of physicians' services and developing methods to measure them. We began by systematically investigating the factors that physicians consider to constitute their work input and other resource costs. We then developed appropriate methods of data collection to measure the various components of resource costs. In addressing these tasks, we brought to bear the skills of economists, measurement psychologists, clinicians, statisticians, and experts in survey research.

To measure resource costs, we developed a model that measures three resource inputs to physicians' services: (1) the work expended on particular services and procedures, encompassing the periods before, during, and after the service; (2) practice costs, including professional liability insurance premiums; and (3) the opportunity cost of training, which represents the income forgone when physicians pursue additional years of specialty training, rather than entering practice. Work is service-specific; practice costs and opportunity costs are specialty-specific.

These three factors combine to produce the resource-based relative value of a given medical service:

$$RBRV = (TW)(1 + RPC)(1 + AST)$$

where

TW = total work input by the physician. Work consists of the mental effort and judgment, technical skill and physical effort required, stress and time spent.

RPC = an index of relative specialty practice costs

and

AST = an index of amortized value for the opportunity cost of specialized training. (Our method spreads the opportunity cost of training over the specialty-specific career lifetimes of physicians.)

The Consultative Component

Because this study called on knowledge from a variety of fields, particularly medical expertise, we augmented our technical work with formal consultation with physicians, third-party payers, consumers, and health-service researchers. The technical and consultative processes were parallel and closely interactive.

For counsel on important aspects of the study, we called on an advisory committee of knowledgeable individuals in medicine, health economics, and health care policy.[1] We consulted with physicians under the auspices of a subcontract calling for support and assistance from the American Medical Association (AMA). The design, conduct, and intellectual responsibility for the study remained, however, with the investigators.

To provide guidance on the study's structure and on the current state of medical practice, we appointed Technical Consulting Groups (TCGs) whose members were nominated by more than 30 specialty societies in a process coordinated by the AMA. We asked for three nominees for each position on the TCGs, and selected from each specialty highly respected physicians representing a broad geographic distribution and a mixture of academic and clinical community-based practices. The 100 physicians selected were organized into 14 TCGs. These physicians served as experts on practice in their specialties; it was understood that serving in this capacity implied no endorsement of the study or its results.

The TCGs helped define physicians' work and its dimensions, commented on methods of measurement and their validation, and evaluated the reasonableness of the results. The TCG physicians were our main source of substantive information on medical practice in the specialties, the most important services and procedures, and the typical complexity of patients seen. Their input contributed significantly to the survey's description of services, and to determining appropriate billing codes. After completion of the national survey of 3200 physicians, the TCG consultants critically reviewed the results with the investigators. Finally, a subgroup from each specialty served on a cross-specialty panel whose task was to link the work of all specialties in a common RBRVS.

Finally, we took the step, unusual for a research project, of conducting a National Consultative Conference, in March 1988, at which individuals representing many interests—medicine, government, health-services research, third-party payers, consumers, business, and unions—critically reviewed the work of the study while it was still in progress. The comments and criticism given at this conference further refined our work.

The Technical Component

The RBRVS was constructed in a multi-step process. We began by developing vignettes of physician services and then mapped these vignettes into the CPT–4, which classifies physician services for purposes of billing. The CPT–4 identifies more than 7000 distinct services and procedures, taking into account variations in levels of service to patients of varying complexity and severity. Though the work of a given specialty may encompass several hundred of these codes, a far smaller number typically accounts for the bulk of the workload.

The total work involved in physicians' services encompasses (1) the physician's time before, during, and after the service itself (pre-, intra-, and post-service), (2) mental effort and judgment, (3) technical skill, (4) physical effort, and (5) stress.

We first selected approximately 23 services in each specialty, studied them in depth, and obtained ratings of the intra-service work they involve from a national survey of a random sample of 3200 physicians. We then estimated the work performed during the pre- and post-service phases. Because each specialty rated relative work on its own scale; to align all the ratings on a common scale, we had to develop a quantitative method of connecting these separate ratings.

We also calculated an index of specialty-specific practice costs—the relative proportion of physicians' gross income spent on practice costs in different specialties.

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[1] The advisory committee consisted of Eli Ginzberg, Ph.D.; Walter J. McNerney; Frank A. Sloan, Ph.D.; Samuel O. Thier, M.D.; and James S. Todd, M.D.

Finally, the opportunity costs (forgone income) of postgraduate medical training were calculated using the duration of residency required for each specialty.

Cross-Specialty Linkage of the RBRVS

Linking the relative-value scales of different specialties was a formidable task. With members of the cross-specialty panel, we selected from a list of cross-specialty services those that are performed in essentially the same way in different specialties. In addition, we identified pairs of services in different specialties that TCG panelists believed to be equivalent in time and intensity. This approach enabled us to develop a grid of services across specialties, with at least four identical or equivalent services connecting one specialty to another. These links make it possible to use quantitative methods and to standardize the ratings of work across specialties.

Extrapolation

For practical reasons, we surveyed only a small number of services performed in each specialty, and extrapolated the work values for those services to a much larger group of services. We identified small, homogeneous families of services as the basic units for the extrapolations, and assumed that charges represent reasonable indicators of relative work within such families. From each family, we selected a benchmark service. The total work value for the benchmark service was obtained from the national survey. Next, we calculated ratios of charges between the benchmark service and nonsurveyed services in the same family. To produce extrapolated work values within a given family, we multiplied the estimated work value of the benchmark service by these charge-based ratios for the nonsurveyed services in the same family.

Practice Costs

We calculated practice costs as a percentage of gross revenue for each specialty, and compared these percentages across specialties. A 1983 survey of physicians' practice costs conducted by the National Opinion Research Center (Sprachmen, Rosenbach, Burich, 1985) provided the most complete information on specialty-specific practice costs; we updated the 1983 survey data with 1986 professional liability insurance premiums.

Opportunity Costs of Residency Training

The length of time a physician spends in training for medical practice varies by specialty, historically ranging from one year of post-medical-school training for a general practitioner to seven years for a neurosurgeon or thoracic surgeon. Each additional year of specialty training imposes additional economic costs on a physician. The opportunity cost of a year of training can be approximated as the difference between a resident's salary and the income the resident could earn in practice.

After calculating the specialty-specific opportunity cost of each year of a residency, we summed the costs of all residency years. We then amortized the total over the average working lifetime in each specialty.

DATA

To gather ratings of work and its dimensions from a large sample of physicians, we designed a straightforward survey instrument that could be administered over the telephone. The questionnaire was carefully tested to minimize any potential misunderstanding that could result in survey bias.

A stratified random sample of physicians was selected from the American Medical Association's (AMA) 1986 Physician Masterfile, which lists every known physician in the United States, including nonmembers of the AMA. We stratified the sample geographically into ten regions, by the national percentage of board-certified physicians in each specialty, and by specialty-specific proportions in each region. We excluded physicians who worked in patient care fewer than 20 hours a week, were in residency training or over 65, or lacked a current address in the AMA Physician Masterfile.

After successfully pilot-testing the survey instrument on four representative specialties—anesthesiology, general surgery, internal medicine, and radiology—the survey was administered to a national sample of physicians by a professional survey firm.

We surveyed 3,164 physicians; 1,977 interviews were completed, for an overall response rate of 62.5 percent. Response rates ranged from a high of 69 percent for radiology to a low of 56 percent for obstetrics and gynecology. To ascertain whether the quantitative measurement of work obtained from the survey was reliable and valid, we performed statistical analyses on the data collected from the pilot study and the national survey.

FINDINGS

Peer Review

In addition to the 100 physician-advisors who had reviewed and commented on our investigation throughout the study, we subjected the methods, data, and results of this study to peer review. This study and its results benefited immeasurably from these peer reviews.

Because of both the unprecedented and sensitive nature of this study, we took the unusual step of conducting a National Consultative Conference in March 1988. Twelve nationally-recognized experts in economics, medicine, statistics, psychology, and health policy were invited to discuss the five papers we prepared for the conference. These papers reported on our methods, data, and preliminary results through February 1988. Many of the 120 attendees also commented on the study. Furthermore, the Health Care Financing Administration independently appointed eight additional outside experts to review our study, including the material presented in the five papers prepared for the Consultative Conference.

Lastly, when the methods, data, and results of this study were submitted to the New England Journal of Medicine and the Journal of the American Medical Association for publication, these journals appointed a total of nine anonymous referees to review our submitted manuscripts. A total of eleven manuscripts, which present all the principal methods, data, and findings of this study, have been published.

Technical Results

This study developed the fundamental concept of a relative-value scale based on resource input, and methods to measure the resource inputs. We have presented the data and process used to derive each component of the RBRVS. Our investigation led to three major findings. (1) We found that physicians' work can be defined by a systematic and rational approach, and measured by the magnitude-estimation method. (2) We found that relative work input for physicians services can be defined and reliably estimated. (3) We developed a topography of physicians work, consisting of four dimensions: time, mental effort and judgment, technical skill and physical effort, and psychological stress.

In every specialty, the means of the ratings of work obtained from a group of about 100 specialists proved reproducible and highly reliable. Moreover, there is a high degree of agreement among physicians on ratings of work within their specialties. The data also display a high degree of consistency, and thus demonstrate internal validity. When we compared one dimension of work obtained from the survey—time—with hospital operating rooms' recorded times, we found times from the two sources for selected surgical services to be very close to each other. This comparison provided an external validity check.

There is no objective standard against which we can compare our results to ascertain how well the measured work input represents reality. Thus we had to rely on the next-best alternative: to subject the results to reviews for reasonableness by practicing physicians. For this purpose, we organized technical consulting groups of 100 physicians in private practice and academic medicine across the United States. The panelists reviewed the ratings of work and its dimensions obtained from the survey. In general, they found the ratings to be reasonable and to conform to the reality they had experienced in clinical practice. These favorable findings from formal statistical analysis and TCG physicians' review results led us to conclude that, in general, the ratings of work are reliable, consistent, and valid.

Second, we found that a common scale can be developed to serve as a basis for inter-specialty relative values. Identical or equivalent services performed by more than one specialty were used to align specialty-specific ratings of work onto a common scale. To fit the linked services together on a common scale, we used a weighted-least-square procedure. This method produced a "best" fitted value, which exhibits the least amount of deviation between the actual and fitted values. We computed approximate confidence limits for the deviations and found that, at the 90-percent confidence level, the limits were 7 percent of the mean. This result suggests that the services we identified are good links between specialties.

Finally, we found it feasible to develop an RBRVS for most services and procedures without having to study each of the 7,000 unique coded services in CPT–4. We designed a method to extrapolate the RBRVs of services studied in depth to those not studied. Our method classified approximately 7,000 services into several hundred homogeneous families based on specialty, category of service, performance setting, anatomic part, and similar factors. We selected a benchmark service within some families for in-depth study, and derived an RBRV for that service. Charge data were then used to extrapolate the RBRV for the benchmark service to other services within that family.

This approach allowed us to use current charge data while largely eliminating any distortion from these charges. This is the case because, although health insurance and other market forces can cause large distortions in charges between families of services, they tend to produce much less distortion within families. This extrapolation method produces reasonable results for most invasive, imaging, and laboratory services. However, because the CPT-4 coding system assigns ambiguous descriptions to the codes classifying evaluation and management services, our use of families is probably not the best extrapolation method for this category of services. This question will be followed up by further research.

RBRVS Results

This study generated six major findings. First, we found that current physician charges are not closely related to resource costs. The current charges-to-RBRVs ratios for most evaluation and management services range from 0.2 to 0.5. For most hospital-based invasive services, the ratio is more than 1.0. Services performed by radiologists have typical charges-to-RBRVs of about 1.0. Relative to resource cost, in other words, evaluation and management services are compensated at a lower rate than invasive, imaging, and laboratory services. Roughly speaking, evaluation and management services are currently compensated at less than half the rate of invasive services. This finding holds true whether evaluation and management services are performed by surgeons, internists, or family practitioners.

Our results also indicate that evaluation and management services performed in hospitals are compensated at a higher rate than the same services performed in office settings. This phenomenon may be attributable to historically more thorough insurance coverage of hospital services than outpatient office services.

For diagnostic radiology, our results show ratios of charges-to-RBRVs far higher than those for evaluation and management services; we thus conclude that imaging services are more favorably compensated than office and hospital visits.

Second, we found wide variation in charges-to-RBRVs ratios within categories of services. This is true both of evaluation/management and invasive services, although the variations are greater among invasive services. Within a specialty, therefore, individual physicians might be differently affected by an RBRVS-based fee schedule, depending on the mix of services they performed.

Third, we divided the work performed by physicians into four dimensions: time, mental effort and judgment, technical skill and physical effort, and stress. All of these factors are important and they are included in the resource-based relative values. Time alone is not adequate to explain work. As a matter of fact, in the RBRVS for surgical services, surgeons rated technical skill as having greater weight than time spent; mental effort and judgment as having equal weight as time spent. So, for surgical procedures, time is only one among four factors for the relative values. On the other hand, in medical specialties, time is shown to have about equal weight as mental effort and judgment, while technical skill has less weight. In comparing surgical procedures and office visits, we found that the intensity (i.e., work per minute) for surgery can be as much as six times the average intensity for visits.

Fourth, we found that work per minute for invasive services varies over a wide range—from 1.9 to 19.4. Variations in work per minute for other categories of services are much smaller, typically a two-fold range.

Fifth, we found only small differences in mean work per minute (an implicit measurement of intensity) in evaluation and management services. Furthermore, when we partition evaluation and management services by setting (i.e., hospital, office, nursing home, telephone), the differences in work per minute become minimal. Physicians' work varies closely with time spent for a patient.

Lastly, we found that pre- and post-service work represent an important component of physicians total work. Though medical practitioners are aware that much of their time and effort are spent before and after performing a given service for a patient, there has heretofore been no systematic study of pre- and post-service work. We found pre- and post-service work to represent close to 50 percent of the total work of typical invasive services, and 33 percent of typical evaluation and management.

IMPACT

We compared the current charges with the resource-based relative values. We found that the current charges do not reflect the required resource costs. For office and hospital visits, the Medicare program is currently paying $25 to $45 for each 100 units of resource cost. Meanwhile, for most surgical procedures and diagnostic tests, Medicare is paying $100 to $160 for each 100 units of resource cost. This finding has important policy implications since physicians are paid very generously for some services, but not for others. Therefore, the economic playing field for physicians is not level. The more generous payment rates for surgery and tests could induce greater and inappropriate volume of these services.

If Congress replaces the current payment system with an RBRVS-based schedule, there will be some significant increases in fees for office, hospital, nursing home visits, and consultations, while surgical fees could be reduced 10 percent to 35 percent. These changes in payment rates would affect physicians' Medicare revenues. To evaluate the potential impact, we simulated the possible effect of an RBRVS-based fee schedule under a "budget neutral" assumption. We also assume that the RBRVS affects only physicians' net income. The simulation was performed with sparse and incomplete data, so it provides a rough indication of the potential effects. Graph C (attached) shows that most specialties will not be affected greatly. Yet, for six specialties, revenues from Medicare could increase or decrease up to 30 percent.

LIMITATIONS AND CRITICISMS

We know there are limitations and shortcomings to the RBRVS. Since the release of our 2,000 page final report to the Health Care Financing Administration, we have received many criticisms of the study. Some criticism is well-founded, while others are not. We present a summary of the important criticisms and explain what we plan to do to address them.

In our final report, we pointed out several limitations of the RBRVS. First, it does not take into account the competency of the physician or the quality of service. It is currently infeasible to differentiate systematically the quality of work performed by 500,000 physicians practicing in the United States. Nonetheless, the RBRVS could incorporate a quality index when accurate physician-specific information does become available. Second, we used the coding system adopted by HCFA (HCFA Common Procedure Coding System—HCPCS) in defining and coding the services. There are, however, ambiguities in this coding system as to the definitions and content of a service. As a result, there are variations in how Medicare carriers and physicians use this coding system, and it will not be possible for us to make precise estimates of the resource cost of all the services unless the coding system is improved.

There is some well-founded criticism of the RBRVS study. It includes criticisms of our method of treating overhead costs, our use of outdated information in calculating overhead cost, our imprecise measurement of work performed before and after a service, the extrapolation of the relative values derived from surveyed services to some nonsurveyed services, the insufficient review and validation of these extrapolated relative values, the inadequate validation of the linked services that we used for cross-specialty alignment, and the degree to which some of the surveyed physicians, were "qualified" to give us valid ratings of physicians' work.

Practice Costs

We have been criticized for our method of treating of overhead costs. Critics argued that our method is not sufficiently refined and that the data we used are outdated. In the study, we have accounted only for the differences in overhead costs between specialties. In addition, we calculated the relative values by spreading the total overhead cost to each service in proportion to its work input. In reality, the overhead may not vary with the physician's work input. Different services may require varying amounts of supplies and services by ancillary personnel, such as nurses or technicians, not in proportion to physicians' work. Further, direct overhead costs differ between the services performed in the office and in the hospital.

These criticisms are justified. Our Final Report acknowledges the shortcomings of our method and data, and they should be substantially improved. This will require, however, an extensive study. The Physician Payment Review Commission has already begun a study to improve our method and to collect the most up-to-date information on overhead costs. In the Phase II of the RBRVS study, we will work with the PPRC to improve the method and data for incorporating the overhead costs into the RBRVS.

Work Performed Before and After a Service

The pre- and post-service work comprises a significant portion of the total work. The methods for their measurement were not as well developed as were the methods for measurement of the intra-service period. Consequently, the values we obtained for the pre- and post-service periods are less accurate and the method required major improvement. In Phase II of the study, we plan to make major revisions in our method and data collection for estimating the work performed during the pre- and post-period. We are testing various new methods with physician focus groups and with pilot surveys. The development and testing of various optional methods would give us the empirical data to select a sound method. We plan to use a new method to obtain accurate information on the pre- and post-service work.

Extrapolation

We have been justifiably criticized for some relative values that were produced from our extrapolation method. The data we used for extrapolation were not adequate to produce accurate values for all services. Moreover, these relative values derived from extrapolation should be carefully reviewed and validated. In Phase II, we plan to work closely with the Health Care Financing Administration and obtain the most accurate data for extrapolation. We will also work closely with carriers to edit the data and interpret them correctly. In addition, we plan to organize panels of physicians to review and validate the relative values obtained from extrapolation.

Coding of Services

In the original Medicare law, Congress allowed the definition and coding of physician services to follow local custom. This is still the case. Consequently, a national coding system, was not fully adopted until 1985. Not all carriers have implemented this national coding and classification system. We found that there are ambiguities in the HCPCS codes, especially for office and hospital visits, and consultations. These ambiguities lead to non-uniform use of the codes by physicians and carriers alike. Each carrier has its own interpretation of the codes. Under varying practices, a 10-minute office visit and a 20-minute office visit could both be classified and paid as an intermediate visit. The content of services in a surgical code also varies between carriers. The problems with the coding system made the development of relative values much more difficult because the same code may mean different services between regions and physicians. We strongly recommend that the Congress require all carriers and physicians to make uniform and consistent use of the HCPCS codes.

"Fitness-to-rate"

Our study has been criticized that some of the data we obtained are from those surveyed physicians who do not frequently perform a given procedure. Some people believe that those who do not frequently perform a procedure are not "fit-to-rate" a procedure. These critics assert that although a specialist is trained to do a procedure, he or she is unable to give a valid estimation of the work involved unless he of she performs it frequently. We have compared our results with other studies which gathered data only from those who have frequently performed the procedures. We did not find a significant difference between our results and those of other studies. Nevertheless, in Phase II of the RBRVS study, for those specialties that will be resurveyed, we will incorporate a question to ascertain how frequently the physician performs a given procedure.

Specialty-specific Concerns

Five specialties—psychiatry, dermatology, cardiovascular and thoracic surgery, ophthalmology, and pathology—have pointed out to us that we have not adequately considered some important and special characteristics of their work. Also, there are coding problems for some of the services of these specialties, and we did not adequately cover the most important services of some of these specialties. Consequently, we have agreed to restudy and resurvey psychiatry and dermatology. Presently, we have met and held extensive discussions with the other three specialties. We are confident that mutually satisfactory agreements can be reached for us to restudy and resurvey these three specialties, if they decide that is the best course of action to address their concerns.

Non-response Rates

The primary data for the study were gathered from surveyed physicians. We had an average response rate of 62.5 percent of the physicians surveyed. Some critics have argued this response rate is too low, and they have asserted that there could be bias introduced by the high non-response rate. These criticisms, we believe, are without foundation. We have conducted statistical analysis to examine whether the non-respondents are similar in character to the respondents, such as their board-certification status and the region where they are located. We found no statistical difference between the two groups. It is well known that is difficult to get physicians to participate in surveys. Physicians are busy people, and they are often surveyed by pharmaceutical companies, government, AMA, medical publications, etc. Hence, doctors often do not respond. Our response rates are higher than the response rates to surveys conducted by many specialty organizations. Their results are often based on response rates of 15 percent to 40 percent.

Other Technical Criticisms

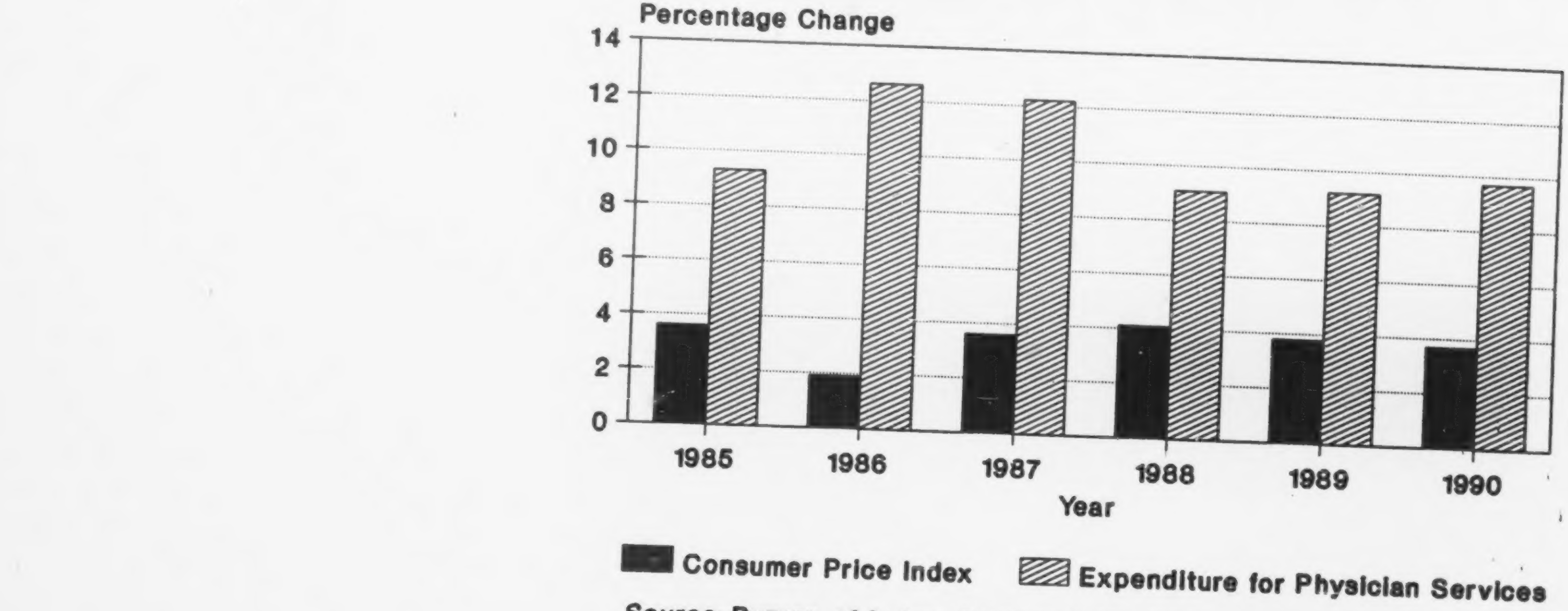
The study has also been criticized for our use of the magnitude estimation method and for taking geometric means to calculate our values. We found these criticisms, often made by people unfamiliar with the technical subject matter, to be without foundation. Our study has been reviewed by nationally-recognized experts in psychology and statistics, who have supported our technical methodology.

RECOMMENDATIONS AND CONCLUSION

1. The internal and external critical reviews of the RBRVS study found that the results of the RBRVS are generally sound and credible; hence the RBRVS method is a feasible alternative for paying physician services. We believe the RBRVS offers a rational and systematic method to establish payment rates. Yes, the RBRVS can be improved and refined, and this effort is already underway. We are confident that we can improve the RBRVS and that it can be completed for implementation by the end of next year.
2. The classification and coding system must be improved to remove its ambiguities. More important, we recommend that Congress mandate the uniform usage and application of the HCPCS coding system, once the needed improvements have been made. Otherwise, the codes will continue to be used differently by carriers and physicians. Without a national uniform coding system, we cannot assess accurately what services have been performed and how much the volume has changed. We cannot prevent the unbundling of services or deter "code-creep" for larger reimbursements. The problems of the current coding system also make it difficult to estimate accurately the resource cost required for ambiguous codes.
3. We recognize that a payment reform based on the RBRVS could have a quite severe financial impact on physicians in several specialties. We would recommend a gradual transition from the current payment method to an RBRVS-based fee schedule to allow orderly and gradual adjustments in physician practices and to avoid sharp disruptions. We believe a four-year transitional period is appropriate.
4. We recommend that evaluation should be integral to implementation of a Medicare fee schedule based on resource input. We do not have adequate information to predict accurately how physicians and patients will react to a change in the relative prices for physician services. There could be a positive effect on access, quality, and the cost of medical services, but there might also be negative effects. We strongly urge that Congress require the establishment of several sites where the effects of an RBRVS-based fee schedule could be carefully evaluated. The information gathered from these evaluation sites could guide the Congress in making midcourse adjustments in the implementation of payment reform.

In summary, the current physician payment system is widely criticized for retaining historically distorted fees. Distorted fees, in turn, present perverse incentives to physicians. These distorted fees could lead to provision of inappropriate services and could promote more rapid inflation in health care costs. We believe that the RBRVS offers a feasible, systematic and rational approach to the establishment of relative values based on resource costs, most notably physicians' work input. By removing the perverse incentives, the RBRVS could enhance cost-effective medical care and ameliorate the physician shortage in some primary-care specialties.

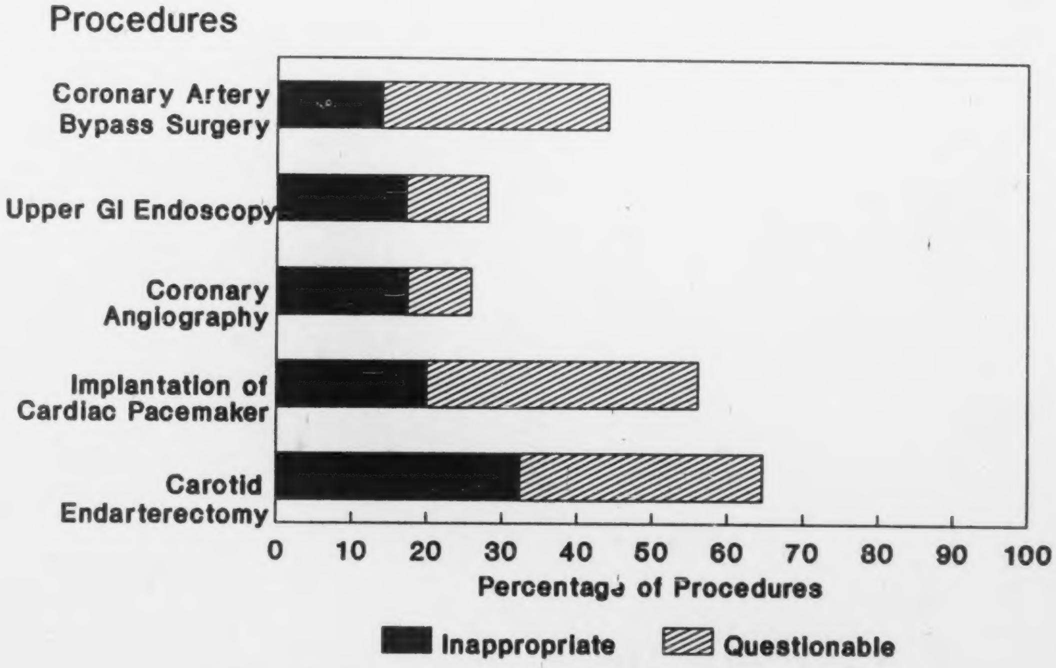
Expenditures for Physician Services Compared with the CPI



Source: Bureau of Labor Statistics; Health Care Financing Administration; Council of Economic Advisors

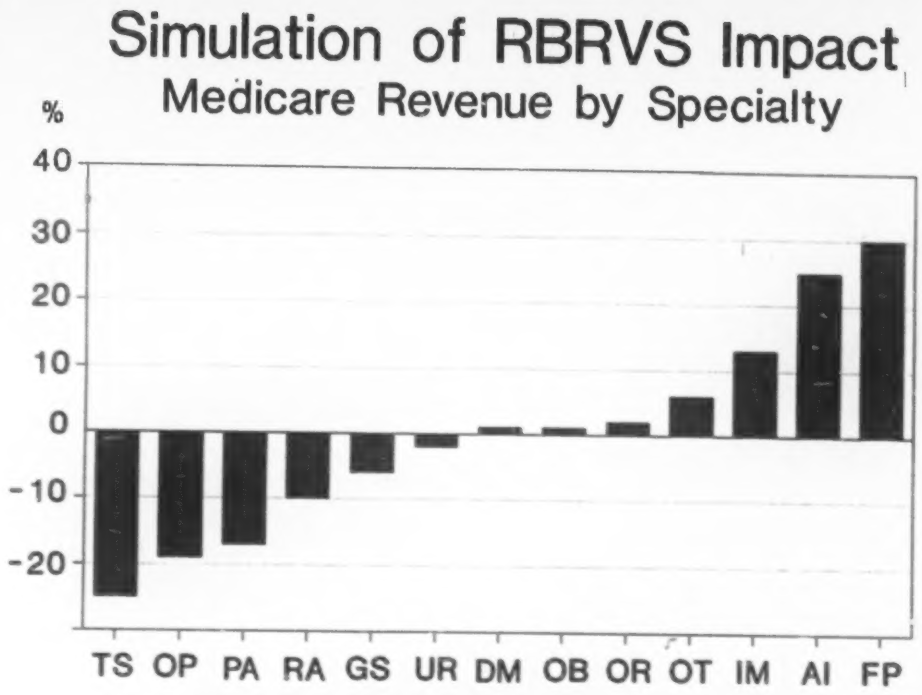
Graph A

Appropriateness of Procedures Performed



Sources: Articles published in the New England Journal of Medicine and the Journal of the American Medical Association.

Graph B



Explanation: TS denotes thoracic and cardiovascular surgery, OP ophthalmology, PA pathology, RA radiology, GS general surgery, UR urology, DM dermatology, OB obstetrics and gynecology, OR orthopedic surgery, OT otolaryngology, IM internal medicine, AI allergy and immunology, and FP family practice.

Note: Simulation is for 1986 Medicare revenue.[1] Two assumptions were used for the simulation: 1.) budget neutrality for Medicare physician payments; 2.) the RBRVS only effects physicians' net income.

Source: Harvard RBRVS Study, March 1989.

Graph C

RESPONSES TO QUESTIONS SUBMITTED BY SENATOR BENTSEN

Question. The American College of Surgeons made a proposal that would base payments on a blended rate that was based part on resource input, and also part on patient demand and efficacy of the service. Why did the commission choose not to use this concept, and stick to a RVS based only on resource input?

Answer. The American College of Surgeons (ACS) proposed to base physician payments partly on resource input and partly on patients' demand and efficacy of service. The ACS assumes that the current charges represent patients' demand and efficacy. This is an erroneous assumption, however. Patients' demand and efficacy are reflected in patient's willingness to pay *only* when these conditions are met: (1) patients have to pay for services themselves without any insurance coverage (then the amount paid by the patient out-of-pocket would reflect the value of the service to the patient) (2) patients have the time and presence of mind to do price-shopping and pick the best surgeon who charges the least to perform a procedure with physicians competing on prices (unless this condition is met, the prices physicians charge are monopolistic prices), and (3) patients can make rational and informed choices as to whether they should have a procedure performed on themselves.

The members of the Physician Payment Review Commission (PPRC) know the market for surgical services does not meet the above conditions; therefore, the surgical charges do not reflect patients' demand. There are several reasons why surgical charges are not the competitive price and therefore reflect the patients' demand. First, there is widespread insurance coverage for surgical services, so patients do not pay directly for these services and are therefore largely unconcerned about what surgeons are charging. Second, patients are not likely to make rational and informed choices when suffering from pain or distress, nor do they have the time to price-shop and select the least expensive surgeon. Finally, the price a patient is willing to pay when his life is in jeopardy does not reflect the patient' demand as defined by economic principles. This is the case regardless of whether the service is performed by a physician, a fireman, a policeman, or a rescue squad. In civilized nations, police work, firefighting, and emergency services have long been organized as public services because the market cannot determine fair prices under those circumstances, and consumers' willingness to pay does not reflect any kind of rational demand.

If the American College of Surgeons is serious about using a blended rate to reflect consumer demand, the minimum condition they should accept is to determine the charges when there is no health insurance coverage for surgical services so the fees could at least represent the monopolistic prices (i.e., what patients are willing to pay from their own pockets when there is little price competition)

Question. The surgeons feel that a demand-side RVS could be developed in much the same way that the resource-based RVS was developed. Dr. Hsiao, you stated at the hearing that development of such a scale was technically possible. What types of measurable factors could be used to develop such a scale?

Answer. At the hearing, I said that the development of a relative value scale to reflect patients' demand can be estimated for some services but not for all services. We can use market prices to approximate patients' demand when the three condition enumerated in Question One plus the following conditions are met:

(a) Patients make repeated purchases of the same service over time so they can switch doctors if they are not satisfied with either the quality or the price of the service provided by a given physician.

(b) The patient makes direct selection of the physician who performs the service. For some specialized services, such as diagnostic radiology, nuclear medicine, anesthesiology, and pathology, patients do not select the physician so these specialized services do not meet this condition.

(c) Physicians do not have the market power to induce demand for their service.

Only *some* medical services satisfy the above conditions in a reasonable way. They may include primary care services, normal child delivery, psychotherapy, etc. The price that patients are willing to pay out-of-pocket for these services could be used as a measure of the patients' demand.

Question. How might this proposed payment reform affect the access Medicare patients have to providers? Would you expect to see fewer physicians willing to care for Medicare patients if a fee schedule based on the RBRVS is implemented?

Answer. A RBRVS-based payment system may improve access to primary care for Medicare patients because of increases in payment rates for these services. In the long run, an RBRVS-based fee schedule would also increase the number of primary-care physicians. Some of these physicians will be likely to practice in rural areas and thus improve access to medical care for the rural residents.

A RBRVS-based payment system would reduce payment rates to surgeons. Some surgeons might be less willing to take care of Medicare patients. However, I do not think many surgeons will do so. There are several reasons for this. First, there is an over-supply of surgeons now. The average surgeon practicing in community hospitals find it difficult to get enough surgical patients. As a result, many surgeons retire early or shift their practice to general practice. Second, surgeons practicing in medical centers are not likely to be affected by the RBRVS. These surgeons are on salary. An RBRVS-based fee schedule will still generate sufficient revenue to pay surgeons' salaries in medical centers. Hence these surgeons are unlikely to turn away Medicare patients. Lastly, under the PPRC proposal, physicians are allowed to do balance billing within limits. The very competent and busy surgeons would balance bill their patients and they do not have to turn away Medicare patients.

Question. The RBRVS does not directly take into account the severity of the patient's illness. Do you think the current coding system adequately reflects variance in illness severity? Will the proposed system be equitable for the physician who cares for a large proportion of acutely ill or frail elderly patients?

Answer. I do not believe the severity of the patient's illness is a problem for the RBRVS. Severity has become a concern because hospital reimbursement had grouped the 9,000 ICDA-9 codes into 467 DRG categories. Hospitals began to raise the issue that severity of illness is not being adequately considered in the DRGs. This argument should not be extended to physician payment. Physician services are separated into 7,000 individual services. This coding is already very detailed, separating out patients into different illnesses and services/procedures performed by the physician. The most common complaint among practicing physicians is that the current 7,000 codes are too refined. It is impractical for them to use all these codes. The claim data bear this out. We found that the charges for several hundred codes make up more than 80 percent of the dollar volume of physician services. Most of the 7,000 codes are used very infrequently. While there is still some variation in patients' severity within each code, but that is inherent in any classification system which groups homogeneous patients and procedures into one code. Even if there are 500,000 codes, critics can still argue there is some variation in the severity of illness within each code. This kind of argument implies that physicians should establish a separate charge for each individual patient. Clearly, that is not practical nor are physicians doing that now. Under RBRVS, we are not changing the current practice where one fee is established for each of the 7,000 codes.

I believe, overall, that the current coding system compensates physicians equitably and fairly for the services they render to acutely ill or frail elderly patients. When physicians take care of these patients, the visits are longer and/or it takes more office and hospital visits to care for these patients. Under the RBRVS, physicians will be compensated proportionately more for the longer visits. As for the more frequent visits for the acutely ill, physicians bill each visit separately and thus receive payment proportionately to the number of visits.

REPONSES TO QUESTIONS SUBMITTED BY SENATOR MITCHELL

Question. You stated that an important source for your work was a survey of practicing physicians, a survey which some have criticized as being too small. I am interested in knowing how representative the survey was of rural physicians?

Answer. Our survey has been criticized by uninformed people as being too small. The number of people who should be surveyed is not determined by the absolute number of people we surveyed, but it depends on how much variation there is between respondents answering a question. Let me illustrate. Among the 110 million American workers, if every worker gave the same answer to a question, then a study would only need to survey one worker to obtain a reliable answer. On the other hand, if every worker has a different answer to a question, then a study would have to survey 110 million people. In our study, we found there is close agreement among physicians as to the work required in performing a given service. Answers from about 40 physicians would give a reliable average rating of work for the services we studied. We obtained responses from approximately 100 randomly-selected physicians in every specialty we had studied twice the number that is needed for statistically reliable answers.

The physicians we sampled represented the actual distribution of physicians who practice in urban versus rural areas. Because there is varied definition of urban versus rural areas, I estimate that we surveyed approximately 300 to 400 physicians practicing in rural areas.

Question. You have outlined a series of enhancements that you wish to make to the RVS, with a possibility of a new version being completed by next year. What is your projection of the effect that a new version would have on the relative gains family practitioners make under this version?

Answer. In our simulation chart, the Medicare revenue received by obstetricians would not be changed greatly. The reason is simple. The highest dollar-volume service performed by obstetricians is delivery of babies. The fees for this service tend to be low in relation to the resource cost, but this service is not performed to Medicare patients. As to other obstetric services, the fees for obstetric surgery tend to be high in relation to resource cost, while office and hospital visits tend to be low. For the Medicare patients, the distribution of services is such that they tend to cancel each other out.

Question. I am surprised to see in your simulation chart that obstetricians would benefit so little from the RVS, especially because stress due to risk is a component of your resource measure. Would you care to comment on this? How necessary is the addition of a medical liability factor to the RVS?

Answer. We are conducting a new study to improve and to refine the RBRVS. This effort is underway. It is too early for me to make any prediction as to how the new results would affect Family Practice because I do not have any facts on which to make such a prediction.

Responses to Questions Submitted by Senator Heinz

Question. One of the major threats to the financial solvency of the Medicare program is the continued rise in the volume of services performed for Medicare patients. Can you speculate as to the effect a change in reimbursement to a relative value scale will have on the volume of services performed?

Answer. I believe one of the causes for the rise in volume of services is due to the distorted fees in our current payment system. This payment system encourages physicians to do as many tests and surgery as possible. Our payment system also encourages physicians and hospitals to adopt new procedures and technology without much regard to their efficacy and cost-effectiveness.

The RBRVS does not directly address the volume issue. However, the RBRVS will correct the distorted incentives in the current system and hence it could help to reduce the rate of increase in volume. Rising medical care expenditures is a result of the interaction between price and volume. Congress cannot control the volume effectively unless you put the price structure right. Moreover, I am not aware that anyone has an effective solution to the volume issue. Most experts believe that we cannot find an effective way to deal with the volume issue for several years. Then why delay a correction of the distorted incentive structure? We can reform the payment system now; then we can install effective controls on volume when that is developed.

Question. Dr. Lee, in acknowledging your pioneer work on RBRVS, has noted a number of changes PPRC is recommending to your model. Would you please comment on which of the changes appear valid and which may be in question. I am especially interested in your thoughts on the pass-through for malpractice costs and the idea of building physician time costs into visit codes, rather than as part of an overall "work" measure.

Answer. In our final report, we recommended that physicians' time be built into the visiting codes. This is based on the empirical data we have collected from the study. Hence, we are in total agreement with the PPRC recommendation on incorporating physician time into the visiting codes. As to medical malpractice cost, this cost is very volatile and varies between regions of the U.S. Hence, we agree with the PPRC recommendation to separate out medical malpractice cost and treat it as a separate item in the RBRVS formula.

Question. The PPRC is recommending an ambitious schedule of implementation—beginning just a year from now. In your view, is this realistic technically and admistratively?

Answer. The PPRC recommends that the Congress legislate a change in physician-payment policy with an interim payment rate implemented in the Spring, 1990. However, the full RBRVS-based payment system will not begin its implementation until 1991. I think congress can legislate policies now because the principle methods and data of RBRVS have been sufficiently developed. After careful and detailed reviews by scores of experts and research organizations, the scientific community found the RBRVS has technical credibility. Therefore, the Congress can place its confidence in the RBRVS as a feasible, rational alternative in paying physician services. The RBRVS should be improved and refined; this work has begun and it will be completed before December, 1990.

I believe it is realistic to begin the implementation of a RBRVS-based payment system in 1991. But I think the new system should be phased-in over a four-year period. Over this period, we can, in an orderly way, deal with administrative and technical problems in implementing the new system. Congress can also exercise its oversight function to monitor and improve the new payment system.

Question. You have worked day in and day out with literally hundreds of some of the best minds in clinical research and practice that run the gamut from general practitioners to specialists. What is your view on the likelihood—from a technical and political perspective—of implementing both a relative value scale and expenditure targets at once?

Answer. One paramount concern of the U.S. Congress is to control the rapidly rising health-care cost, while not reducing the quality of care. The RBRVS would put in the right incentive structure to reduce the unnecessary surgery and tests, while encouraging physicians to give better primary-care services. However, it is not likely that the RBRVS-based fee schedule would control sufficiently the growth in total health expenditure. A RBRVS-based payment system combined with expenditure targets would control the rising cost more effectively. An expenditure target alone would reduce the quality of care and access unless there is simultaneous reform in the payment method.

Question. You suggest in your testimony that it may be prudent to test RBRVS prior to implementation. This is a concept I have consulted with several researchers on, only to be told that it is technically not feasible. How would you design such a demonstration and how would you convince specialists in the demonstration area to accept less money in order to test a payment system they do not fully support?

Answer. In my testimony, I recommended that if the RBRVS is implemented, we should have evaluation sites to assess the impact of RBRVS so the Congress can take corrective action to refine the implementation. Each evaluation site could be a large community or a State. I would design an evaluation study where one region uses the RBRVS by all-payors, another region only uses RBRVS for Medicare, and another region uses RBRVS for Medicare and Medicaid. Then we can assess the impact of RBRVS on access to care by Medicare patients, and impact of RBRVS on cost inflation. We can compare results from the partial-payor system with an all-payor system. There are other feasible ideas for evaluation or demonstration studies. For example, in demonstration projects, physicians in a Preferred Provider Organization (PPO) plan could be paid based on RBRVS. This is already being done in some localities. I would be happy to meet with you and your staff to discuss the demonstration projects.

Responses to Questions Submitted by Senator Chafee

Question. The PPRC recommends that we set an expenditure target for physician payments under the proposed fee schedule—starting out with a national target, and then perhaps moving to sub-national targets. Presumably, if a target wasn't met in any given year, then the fee schedule for the doctors in that group would be reduced, or increased at a slower rate. How, under this arrangement, do we avoid a situation where Doctor A, who has relatively less expensive patterns of practice, ends up bearing the burden for Doctor B's relatively more expensive patterns of practice?

Answer. The point implied in your question is a real problem. Under an expenditure target, physicians who place public interest above their own interest by holding down inappropriate services will be penalized along with those physicians who increase the volume of their services to generate a desirable income. This criticism of expenditure target can be overcome, however. A national expenditure target is only a signal to the whole medical profession that they must take collective responsibility to hold down unnecessary utilization. Otherwise, stronger measures might be used to monitor each physician's practice. Since the majority of physicians are honest, fair and public-minded, they may monitor and exert peer pressure on that small fraction of physicians who may abuse the system by increasing the volume of services they perform, regardless of whether the services are appropriate. If the medical community is unwilling or unable to control those physicians who abuse the system, then the government will have to step in. In that circumstance, there are many ways to identify the abusers rather than penalizing all physicians when the expenditure target is exceeded. For example, the targets can be set at the community or hospital level, hence penalizing the small group rather than all the physicians. Alternatively, we can identify those physicians whose volume of services has taken a dramatic jump. These physicians' services can be reviewed in greater detail—and if abuse is found, their payments can be cut back.

In sum, it is extremely important for the Federal Government to close the checkbook on how much we will spend for physician services. When the current open-checkbook is closed, only then will there be incentive for the delivery of medical services to be rationalized and for physicians to consider the cost and efficacy of their services. Expenditure target is an effective means to close the checkbook. The detail in implementing the expenditure target remains to be worked out, depending on how the whole medical profession accepts the collective responsibility to monitor and control those physicians who may abuse the system.

Question. Can you tell us how what is proposed here compares to the Canadian system?

Answer. Canada has a single payor system where physicians receive all their payments fro the provincial government's insurance plan. Since each province can monitor the total volume of services billed by each physician, the expenditure target has worked quite effectively in many Canadian provinces. In the United States, the Medicare program makes up only 20–25 percent of the average physician's revenue. Therefore, while I fully support the expenditure target as a sound and much-needed public policy, I believe the implementation of the expenditure target must follow a different path than that used in Canada.

PREPARED STATEMENT OF PHILIP R. LEE

The Physician Payment Review Commission has developed proposals to rationalize the pattern of payments to physicians by Medicare and to slow the rate of increase in program costs so that they are affordable to the beneficiaries and the taxpayers. It met last week and approved the recommendations to be included in its 1989 Report to Congress, which will be submitted by April 30. I appear before you today to discuss these recommendations and answer your questions.

To rationalize the pattern of payments by Medicare, the Commission proposes a Medicare Fee Schedule based primarily on resource costs. To limit beneficiary financial liability, it recommends limits on balance billing. To control growth in expenditures, the Commission proposes the use of expenditure targets and increased research on effectiveness of medical services and development of practice guidelines.

MEDICARE FEE SCHEDULE

In its report to Congress two years ago, the Commission called for the development of a fee schedule for Medicare. We are now proposing that the current CPR method for paying physicians be replaced by a Medicare Fee Schedule that is based primarily on resource costs. The Commission recommends enactment of legislation this year to establish a Medicare Fee Schedule, with a transition fee schedule implemented within six months of enactment to move the payment system in a series of steps toward full implementation of the Medicare Fee Schedule in 1992. The Commission also recommends that the Medicare Fee Schedule should include all specialties, including radiology and anesthesiology for which separate fee schedules now exist for Medicare payment.

A fee schedule consists of:

- a *relative value scale (RVS),* which indicates the value of each service or procedure relative to others,
- a *conversion factor,* which translates the RVS into a fee for each service, and
- a *geographic multiplier,* which indicates how payment for a service is to vary from one geographic area to another.

Relative Value Scale

The Commission has reached a number of conclusions about the design of the relative value scale for the Medicare Fee Schedule. I will briefly describe our recommendations and then provide some background for the Commission's decisions.

The Commission recommends that the relative value scale (RVS) be comprised of two cost elements: relative physician work and practice costs.

With respect to relative physician work, the Commission favors:

- the use of the Hsiao methodology for estimating relative physician work, with refinements based on current work by Dr. Hsiao and analyses currently underway by the Commission
- adoption of a policy developed by the Commission to standardize the definition for all surgical global services, and
- modification of the current coding system for evaluation and management services to incorporate time into the definition of visit codes

For practice costs, the Commission proposes:

- use of a Commission-developed additive formula for incorporating practice costs into the RVS
- initial use of the Commission's refined estimates of practice costs by specialty, to be superseded by estimates of practice costs by category of service.
- developing a separate practice cost factor for professional liability insurance premiums

Relative Physician Work. The Commission has carefully evaluated the pioneering work by William Hsiao and his colleagues at Harvard University to develop a resource-based relative value scale. As have others, the Commission has found the methodology for estimating relative physician work to be sound and has drawn heavily on it in developing its RVS for the Medicare Fee Schedule. The Commission's evaluation calls for additional research to be undertaken by Dr. Hsiao and the Commission staff to strengthen the results of the study. Most of these tasks are already underway.

A national fee schedule requires that the codes for physician services be interpreted uniformly by all physicians and carriers. Only then can accurate relative values be assigned to each service so that fees reflect the resource costs associated with providing that service. The Commission's recommendations call for changes related to coding in two important areas: surgical global fees and evaluation and management services.

Codes for Surgical Global Services. With the unanimous agreement of a consensus panel made up of surgeons and carrier representatives, the Commission has developed a policy defining which services associated with an operation are to be included in the global payment for surgery and which are to be paid separately. Using data from the Hsiao study, the Commission has calculated the relative values for each operation to conform to this policy.

Codes for Evaluation and Management Services. Physicians cannot accurately use the current codes for evaluation and management services (commonly referred to as visit codes) to reflect their time and work, because the levels of service (e.g., brief, intermediate, comprehensive) are not precisely defined. Therefore, it is difficult to assign accurate values to current visit codes in a resource-based fee schedule. Analysis by the Commission and by Dr. Hsiao and his colleagues suggests that the physician's time is a good predictor of the work involved in each type of visit (e.g., hospital visit, office visit, new patient, established patient). The Commission recommends that time be incorporated into the definitions for visit codes. This coding reform would allow more accurate relative values to be assigned to these services and help physicians use the codes properly. Carriers would also have a way to determine whether physicians were billing correctly for these services.

With work currently underway by the Commission, Dr. Hsiao and the AMA-sponsored CPT Editorial Panel that oversees the CPT coding system, we expect definitions for visit codes to be revised and individual relative values to be assigned within the next year, well before full implementation of the Medicare Fee Schedule.

Grouping of Codes. Given the work currently underway to modify the coding system for the Medicare Fee Schedule, the Commission recommends the postponement of the legislative mandate to "group codes for payment purposes" by January 1, 1990.[1] The goal of this mandate is to control misuse and abuse of the coding system under the current payment method. Analysis by the Commission suggests that this could be accomplished more effectively by integrating precise definitions for codes with more rational fees for physician services.

Practice Cost Formula. The Commission has developed a formula for incorporating practice costs into the RVS that allows for overhead to be calculated independently from physician work. The original formula developed by Dr. Hsiao allowed changes in estimates of physician work to affect the calculation of overhead. This distorted the relative values and led to an overestimate of the impact of the shift to a fee schedule. As a result of the Commission's correction in the formula, the magnitude of changes in fees and impacts on different specialties is almost halved from the preliminary estimates reported by Dr. Hsiao and his colleagues last summer. From our discussions with Dr. Hsiao, we understand that he agrees with the Commission's modification of the formula.

Professional Liability Insurance. Insurance coverage for professional liability represents a major cost to physicians that varies substantially by specialty and geographic area. To assure that the fee schedule adequately accounts for differences among risk classes (e.g., physicians doing no surgery versus thoracic, vascular and orthopedic surgeons) and localities (e.g., Florida, Idaho) used in setting premium rates, the Commission recommends that professional liability insurance premiums should be treated as a separate practice cost factor.

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[1] Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509), Section 9331(d)(2).

Updating the Relative Value Scale. Revisions in the relative value scale will be required to account for the introduction of new technology, changes in the use of existing technology and in clinical approaches to care, and refinements in the coding system. The Commission recommends that the process used to develop the Medicare Fee Schedule, in which the Commission provides the Congress with the information and advice it needs to make policy decisions, be used for updating the relative value scale. That process has been successful in accomplishing the technical and policy development tasks required, and it provides substantial opportunity for organizations representing physicians, beneficiaries and others affected by the policy to participate in the decision-making process.

Physicians, in particular, have a major role to play in revising the relative value scale. The Commission will continue to work closely with the American Medical Association (AMA) and the specialty societies. If the medical profession decides to coordinate its input on updating the relative value scale through the AMA, the Commission would find that an acceptable process.

Conversion Factor

The conversion factor transforms the RVS into a schedule of dollar payments for each service. The Commission recommends that the initial conversion factor be set so that outlays for physicians' services projected under the fee schedule are the same as those projected under the current payment system.

The conversion factor should be updated annually. The formula used to determine the update should have as one element the difference between targeted and actual expenditures. I will describe how the formula would be used when I turn to expenditure targets.

Geographic Multipliers

The Commission recommends that the geographic multiplier reflect only variation in overhead costs of practice. The amount physicians receive for their time and effort, after subtracting overhead costs, should not vary by locality. Therefore, if physicians in two parts of the country provide the same quantity and mix of services to Medicare beneficiaries, they would receive the same net income from Medicare. This policy would reduce substantially the magnitude of geographic variation in fees.

Specialty Differentials

The Commission recommends that when a service provided by physicians in different specialties is essentially the same, the payment should be the same. Therefore, specialty differentials—differences in payment to physicians of different specialties for the same procedure code—would be eliminated under the fee schedule.

In some cases, physicians in different specialties provide different services under the same code, and yet receive the same payment, because distinct codes that would accurately capture these differences do not exist. These legitimate differences, when substantiated, should be recognized by establishing new codes. Identification of such coding changes would be part of the process for updating the relative value scale.

Assignment and Balance Billing

The Medicare Fee Schedule must be accompanied by policies to limit beneficiaries' financial responsibility for charges in excess of what Medicare allows. The Commission does not recommend mandatory assignment but proposes the following set of policies that together provide increased protection for beneficiaries:

- limitations on charges for unassigned claims to a fixed percentage of the fee schedule amount. These charge limits would replace current MAAC limits. Federal legislation in recent years has set two precedents for the amount of balance billing allowed. In one (overpriced procedures), the charge limit, after a phase-in period, was set at 125 percent of the Medicare allowed amount; in the other (the radiology fee schedule), the limit will be phased in to 115 percent.
- elimination of balance billing for qualified Medicare beneficiaries. This requires clarification of the provision in the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360) that requires state Medicaid programs to pay Medicare cost sharing for beneficiaries seeking this assistance who are not otherwise eligible for Medicaid, but who have incomes below the federal poverty level. The current legislation covers Medicaid payment of deductibles, premiums and coinsurance, but does not require physicians to accept the Medicare allowed charge as payment in full, as they do for other Medicare beneficiaries covered by Medicaid.

- continuation of the Participating Provider Program and its payment differential that provides higher fees to participating physicians.

The Commission has concluded that the market for physicians' services does not function well enough to preclude the need for financial protection for Medicare beneficiaries. Without limitations on balance billing, beneficiary financial protection would suffer. On the other hand, the Commission does not recommend mandatory assignment. Limited balance billing would provide a safety valve concerning errors in setting fee schedule amounts and an opportunity for those physicians who are especially highly regarded by patients or who systematically take on the most difficult cases to be paid more than the fee schedule amount.

Impact on Physicians and Beneficiaries

The Commission has constructed simulation models to project the impact of the Medicare Fee Schedule on categories of physicians and beneficiaries. Table 1 shows the changes in Medicare payments for selected services. Note that fees for evaluation and management services, such as office visits and hospital visits, would increase and fees for many surgical procedures would decrease. Table 2 shows the impact on major specialties included in the first phase of the Hsiao study. Medicare payments would increase for family physicians and internists and decrease for thoracic surgeons, ophthalmologists, and radiologists.

The Medicare Fee Schedule would change the distribution of payments among geographic areas (Table 3). Using a geographic multiplier that reflects overhead costs only, payments to physicians in rural areas would increase. Those to physicians in very large metropolitan areas would decrease.

Table 4 shows the impact on out-of-pocket payment of coinsurance and balance bills for different categories of beneficiaries. All of the categories identified would experience a moderate reduction in costs, most of which would result from the limit on balance billing. Indeed, the percentage reductions in balance billing alone are much larger. The magnitude of these reductions is relatively uniform across the different categories of beneficiaries.

Transition

The Commission recommends a transition from the current payment system to full implementation of the Medicare Fee Schedule. This would give physicians and beneficiaries time to adjust, allow for midcourse corrections, and increase the chances that private payers will change their policies as Medicare changes are being implemented.

The transition must be designed to avoid disruption of the administration of the program by carriers. The Commission's plan would create a Transitional Fee Schedule that would retain customary and prevailing charge screens. It would base changes in prevailing screens on the difference between current payments and those projected for the Medicare Fee Schedule. A projected fee schedule amount would be calculated for each service and procedure. Services would be grouped into categories that are relatively homogeneous, such as office visits and major operative procedures. For each category, the percentage difference between the fee schedule amount and the average allowed amount under current policy would be calculated.

For the first year of the Transitional Fee Schedule, the prevailing charge of each procedure would be changed by one-fifth of this percentage difference. Thus, for example, if office visits are to increase by 25 percent under the Medicare Fee Schedule, the prevailing charge for each type of visit would increase by 5 percent during this first year. For the second year of the transitional fee schedule, prevailing charges would be adjusted by an additional one-fourth. Comparable geographic adjustments to prevailing charges would also be included. We have discussed this approach with knowledgeable experts since the Commission meeting and expect to make refinements based on their advice.

Implementation of the Transitional Fee Schedule would begin about six months after enactment of the legislation. After two years of experience, the full Medicare Fee Schedule would be implemented. At this point, coding reforms and changes in locality boundaries would be implemented. In addition, prevailing and customary charge screens would be eliminated so that all services would be paid at the fee schedule amount.

POLICIES TO SLOW INCREASES IN EXPENDITURES

From 1980 to 1988, Medicare outlays for physician services tripled. Premiums now amount to $334.80 per year. Neither the taxpayers or the beneficiaries can afford continued increases of this magnitude. Decisive steps to slow these increases are needed now.

The preferred way to contain costs is to reduce the provision of those services that are unnecessary and inappropriate. In this way, access and quality of care would not be sacrificed in the course of slowing expenditure growth.

The Commission recommends that three policies be pursued:

- giving physicians collective incentives to contain costs through expenditure targets,
- increased research on effectiveness of care and development and dissemination of practice guidelines,
- improvements in utilization management by carriers and peer review organizations (PROs).

Expenditure Targets

The Commission recommends that a national expenditure target for physicians' services under Part B be used to determine annual conversion factor updates under the fee schedule. The target would reflect increases in practice costs, growth in the number of enrollees, and a decision concerning the appropriate rate of increase in volume of services per enrollee. The last would reflect tradeoffs between beneficiary needs, technological advances, and affordability.

If actual expenditures during a year are equal to targeted expenditures, then the conversion factor update for the following year would be equal to the increase in practice costs. The update would be increased or decreased to reflect differences between actual and targeted expenditure increases.

As an example, assume that practice costs are increasing by 4 percent, enrollment is growing 2 percent, and volume of services is projected to increase by 7 percent per enrollee. This would lead to a 13 percent increase in expenditures. Now assume that a target of 11 percent is chosen, which would permit a volume increase of 5 percent. If actual expenditures rise 13 percent, then the conversion factor update for the following year would be 2 percent (4 - 2). If actual expenditures rise only 9 percent, then the conversion factor update would be 6 percent (4 + 2).

Expenditure targets are designed to stimulate efforts by the medical community to work with the Medicare program to increase knowledge of the effectiveness of services and to use this knowledge to increase the appropriateness of care. Encouragement would come from tying the annual update in the Medicare Fee Schedule conversion factor to the difference between the rate of increase in expenditures for physicians' services and the target rate of increase.

In order to allow time for the necessary infrastructure to control-costs to develop, the Commission recommends that target rates of increase for the first few years not depart substantially from baseline rates of increase.

The Commission recommends beginning with a single target at the national level, but anticipates that the policy will evolve to one with multiple targets. For example, targets could be established for states or carrier areas or for categories of services (for example, separate targets for surgery and other services). Broadening the target to include the rate of hospital admissions is another possible direction. The Commission has already studied several of these options and will continue to do this work.

Expenditure targets would not alter the financial incentives for individual physicians and their patients. Rather, the incentives would fall to the physician community, which could respond through education and support of the existing infrastructure of medical review. For example, the American Medical Association and national specialty societies could develop practice guidelines and disseminate them. They could provide technical assistance to carriers and PROs in the development of criteria for review and political support for sanctions of physicians who persisted in providing care that is inappropriate and does not meet standards of quality.

Effectiveness Research and Practice Guidelines

The Commission recommends a substantial increase in federal support for building our knowledge of the effectiveness and appropriateness of medical practices and getting that knowledge to practicing physicians and their patients. We need to know more about which of our diagnostic tools work, and which patients would benefit from particular therapy. This knowledge is essential if we are to reduce unnecessary and inappropriate services.

To increase this knowledge, we need more research to determine the medical outcomes and the costs of alternative medical practices and procedures, and to determine the best ways to organize and provide care. This work would include clinical trials, epidemiological studies of data generated by clinical practice, analyses of the cost-effectiveness of alternative ways to organize care, and assessment of techniques used in managed care to influence physicians' clinical decisions.

The knowledge we have about effectiveness and appropriateness must be made available to physicians and their patients. Practice guidelines synthesize the best that we know from research and the judgments of practicing physicians, into a form that can be readily used. The Commission recommends that the federal government actively encourage the development and dissemination of practice guidelines so that they are incorporated into physicians' practices, made available to patients, and used as the basis for coverage and payment, and for medical review criteria by hospital medical staffs, carriers, and PROs.

The Commission calls for the federal government to support practice guidelines through funding, coordination and evaluation. Funds should be used to support and build on existing private sector activities by the medical profession and others. Federal oversight should focus on insuring the integrity of the process, including the quality of the methods used and of the resulting guidelines, and facilitating efforts among those involved in developing the guidelines to share information, identify issues and set priorities.

The federal government also has a role as administrator of Medicare. The Health Care Financing Administration should reinforce the importance of basing medical review on sound criteria by assisting PROs and carriers in selecting and using review criteria that are consistent with practice guidelines.

Utilization Review

The Commission supports the current efforts by HCFA to move toward a more comprehensive approach to medical review and calls for further actions to strengthen the review process.

If utilization and quality review are to be effective tools both to improve the quality and efficiency of care and to control the growth in Medicare expenditures, the Medicare program will have to create a comprehensive medical review system that looks beyond individual services to complete episodes of care. This requires systematic integration of information drawn from claims data, analysis of practice variations and peer review of physician practice.

To take on these responsibilities, it is essential that carriers and PROs have additional resources and time to build the necessary capacity. It will also require more administrative flexibility and the cooperation of the medical community. The Commission will discuss in its forthcoming report a number of specific recommendations to structure and focus the transition from the current system that has emphasized claims payment to one of comprehensive review.

INFRASTRUCTURE FOR PAYMENT REFORM

Successful implementation of the payment reforms described above will require investments in the administrative infrastructure of Medicare. We applaud recent efforts by HCFA to introduce a unique physician identifier, to incorporate diagnostic information on claims forms, and to develop a common working file including data from both Part A and Part B.

The Commission recommends two further changes to strengthen the ability to implement these payment reforms. First, Medicare should require providers to submit all claims, whether or not assignment is accepted. Second, HCFA should take steps to accelerate the trend towards electronic claims submission. The ability of the carriers to implement a fee schedule and expand their medical review activities is dependent on funding that is adequate and predictable. Unfortunately, this cannot be taken for granted. While funding for medical review activities of carriers was increased for the current fiscal year, the President's budget for 1990 would cut funding by 19 percent. In a program trying to hold back outlay increases in the range of $4 billion per year, attempts to shave spending for administration (in particular, medical review) are poorly conceived. If we are to attempt major reforms in this program, we must assure that the administrative resources are there to carry them out.

CAPITATION

Some have expressed concern that certain types of prepaid health plans have failed to establish strong organizational structures and management systems and instead have relied heavily on financial incentives to physicians to control costs, posing a risk of underservice to enrollees. This concern led Congress in 1986 to prohibit HMO and CMP use of financial inducements to physicians to reduce or limit service to Medicare beneficiaries. The provision was not scheduled to take effect until 1990 in order to permit time to substitute a less sweeping limitation.

While use of financial incentives to physicians raise important concerns regarding patient care, broad prohibitions may not be in the interest of Medicare beneficiaries. First, we have no definitive information concerning whether or not risk-sharing arrangements now have an adverse effect on access or quality. Second, such restrictions could result in the termination of many HMOs' risk contracts with Medicare and reduce beneficiaries' access to prepaid plans. Medicare beneficiaries comprise a very small proportion of HMO enrollment, so restrictions on practices that HMOs consider important to their success could lead many to turn away from the Medicare program.

The Commission has developed proposals to restrict only the more problematic forms of financial incentives. It recommends that health plans limit the total risk assumed by physicians through some form of reinsurance or "stop loss" provision and that they rely primarily on incentives to groups of physicians rather than to individual physicians. Health plans should also disclose to both physicians and enrollees appropriate information on risk-sharing arrangements.

In addition to limitations on the use of financial incentives, the Commission recommends efforts to strengthen Medicare's external review processes applicable to prepaid plans and the conduct of periodic surveys of beneficiary satisfaction. Finally, the Commission recommends additional research to identify the effects of patient characteristics on the use of services and on the impact of risk-sharing arrangements on physician behavior.

CONCLUSION

Three years ago the the Congress created this Commission with a mandate to suggest policies to rationalize the payment for physicians' services by the Medicare program and to slow the rate of growth of expenditures for these services. We believe that a Medicare Fee Schedule will serve to rationalize payments by tying them to resource costs. It will be simpler and easier to understand for both physicians and beneficiaries. It will promote better care and provide additional financial protection for beneficiaries. Expenditure targets will help slow the increase in Medicare expenditures so that we as a society can meet other pressing social needs. And increased effectiveness research and practice guidelines will provide us with the knowledge and means to manage available health care resources more wisely. With these changes, we believe that Medicare can continue to meet the medical needs of our elderly and disabled citizens.

TABLE 1.—NATIONAL MEAN ALLOWED CHARGES IN 1988 FOR SELECTED PROCEDURES (MEDICAL FEE SCHEDULE AND CPR SYSTEM)

		MFS ($)	CPR ($)	Change (%)
	Internal Medicine			
	Office Visits:			
90050	limited	29.3	22.8	24.2
90060	intermediate	35.3	28.0	26.2
	Hospital Visits:			
90250	limited	33.3	25.9	28.5
90260	intermediate	40.1	29.7	34.8
	Other:			
90620	comprehensive consultation	104.4	92.7	12.6
93000	electrocardiogram, complete	24.6	34.9	−.29.5
71020	x-ray exam of chest	28.8	37.9	−.23.9
	Ophthalmology			
66984	remove cataract, insert lens	1163.3	1467.1	−20.7
92014	eye exam and treatment	39.4	41.7	.−5.5
	Orthopedic Surgery			
27130	total hip replacement	1954.5	2404.0	−18.7
27236	repair femur fracture	1187.4	1302.3	.−8.8
27244	repair femur fracture	1188.0	1299.3	−8.6
	General Surgery			
35301	rechannel of artery	1154.1	1573.4	−26.6
44140	partial removal of colon	1054.6	1255.8	−15.2
49505	repair incuinal hernia	405.0	587.9	−31.1
	Urology			
52000	cystoscopy	111.1	104.9	5.9

TABLE 1.—NATIONAL MEAN ALLOWED CHARGES IN 1988 FOR SELECTED PROCEDURES (MEDICAL FEE SCHEDULE AND CPR SYSTEM)—Continued

		MFS ($)	CPR ($)	Change (%)
52601	prostatectomy (TUR)	919.9	1128.0	−18.5
	Radiology			
70470	contrast CAT scans of head	77.6	112.9	−31.3
71020	x-ray exam of chest	16.9	14.7	15.1
	Thoracic Surgery			
33512	coronary artery bypass	2815.6	3594.4	−27.7

TABLE 2.—PERCENT CHANGE IN MEDICARE ALLOWED AMOUNTS BY SPECIALTY UNDER MEDICARE FEE SCHEDULE COMPARED TO CPR SYSTEM

Specialty	Percent change
Medical:	
Internal Medicine	17.8
Family Practice	39.6
Dermatology	1.0
Surgical:	
Ophthalmology	−16.4
General Surgery	−10.5
Orthopedic Surgery	−7.7
Urology	−4.0
Thoracic Surgery	−19.2
Otolaryngology	6.8
Obstetrics/Gynecology	0.6
Hospital Based:	
Radiology	−25.3
Pathology	−24.2
Anesthesia	*na*
Other Physicians	4.9

TABLE 3.—PERCENT CHANGE IN 1988 MEDICARE ALLOWED AMOUNTS BY AREA UNDER MEDICARE FEE SCHEDULE COMPARED TO CPR SYSTEM

Area [1]	Specialty group	Percent change
Very Large Metro	Medical	−1.2
	Surgical	−25.6
	All physicians	−14.3
Large Metro	Medical	17.4
	Surgical	−12.2
	All physicians	−3.0
Other Metro	Medical	26.4
	Surgical	−7.0
	All Physicians	3.0
Large Rural	Medical	31.5
	Surgical	−.5.5
	All Physicians	12.8
Other Rural	Medical	38.4
	Surgical	−6.6
	All Physicians	15.1

[1] Very Large Metro areas include counties in MSAs of 5 million or more populations, large metro includes counties in MSAs of 1 million to 5 million population, other metro area are all other metropolitan counties.

Large rural (non-metropolitan) counties have population of 25,000 or more, other rural includes all other nonmetropolitan counties.

TABLE 4.—CHANGE IN MEAN BENEFICIARY COINSURANCE PLUS BALANCE BILLING FOR MEDICARE PART-B PHYSICIAN SERVICES 1988 UNDER MEDICARE FEE SCHEDULE COMPARED TO CPR SYSTEM (120% BALANCE BILL LIMIT)

Beneficiary category	Expenses in dollars and as percent change from baseline		
	CPR baseline ($)	MFS ($)	MFS (%)
All:	216	163	−25
<65 yrs	194	154	−21
65–74	214	157	−27
75–84	232	177	−24
85+yrs	191	135	−19
Males:	239	178	−25
white	246	182	−26
non-white	164	135	−18
Females:	200	152	−24
white	209	158	−24
non-white	122	102	−16
Area:			
very large metro	281	193	−13
large metro	233	180	−23
other metro	213	161	−24
large rural	188	143	−24
other rural	176	133	−25
Income:			
poor	108	85	−21
near poor	194	148	−24
1.6–2.0 x poverty	210	162	−23
2.1–3.0 x poverty	237	180	−24
>3.0 x poverty	263	192	−27
Hospitalized during year:			
Yes	543	408	−25
No	116	88	−24

RESPONSES TO QUESTIONS SUBMITTED BY SENATOR BENTSEN

Question. The American College of Surgeons made a proposal that would base payments on a blended rate that was based part on resource input, and also part on patient demand and efficacy of the service. Why did the Commission choose not to use this concept, and stick to a RVS based only on resource input?

Answer. Last year, the Commission reviewed alternative conceptual bases for the relative value scale (RVS) that would underlie the Medicare Fee Schedule. It considered both historical charges and resource costs as two major options. The American College of Surgeons recently proposed blending both concepts in determining relative values, arguing that such an RVS would then reflect resource inputs, patient demand, and value to the patient. In its 1988 report to Congress, the Commission recommended basing the RVS primarily on resource costs, and the fee schedule that it has proposed this year is based on resource costs. A resource-cost basis for the RVS would reflect estimates of what relative values would be under a hypothetical market that functions perfectly. Under such a market, competition drives relative prices to reflect the relative costs of efficient producers.

The Commission sees several problems with basing a fee schedule on patient demand factors. The rationale for using what physicians have historically charged is that charges are the outcome of a market for physician services, and so reflect not only physicians' costs but also value to the patient. But the Commission has concluded that the market for physicians' services does not function well. The combination of extensive health insurance, a lack of information on the costs and benefits of services, and the inability of patients to shop for physician services particularly when they are ill removes many of the forces that drive prices to competitive levels. Moreover, there does not appear to be any sound way to estimate the value to the patient of a given service or procedure. Such value is patient-specific, depending on his or her medical problems. For example, if a patient with very poor vision could have the problem corrected by a pair of eyeglasses, wouldn't that pair of glasses be as highly valued by that patient as cataract surgery that provided a similar outcome to another patient? For these reasons, current charges cannot be used to represent patient demand for services, and blended fees for services would retain the distortions in the payment system that gave rise to demands for payment reform.

Question. I appreciate that the Commission is making recommendations which it believes are good health policy. We in the Congress are faced with balancing good health policy with budget constraints, and this year as in the past we are faced with the prospects of making substantial cuts in the Medicare program. If we must make cuts in physician payments for next year, are there parts of your recommendations that can be implemented quickly to achieve budget savings in the short term that are consistent with the long-term goals embodied in your recommendations? For example, can the RBRVS be used to identify overpriced procedures for which payment levels could be reduced immediately?

Answer. Budget targets for 1990 could be met either in conjunction with the implementation of a Medicare Fee Schedule or as ad hoc adjustments to the current payment system. For example, if implementation of a fee schedule was begun in 1990, the update in the Medicare Economic Index (MEI) could be delayed or reduced. Then, when the conversion factor for the initial stage of fee schedule transition was calculated, it would use this reduced baseline. Alternatively, ad hoc adjustments to the current system could be made. Certainly, it would be wise to use all of the information that has been developed to construct a fee schedule proposal—the Hsiao study and the analysis by the Commission—to develop these adjustments.

Question. The Commission recommends establishing expenditure targets for physician services. I assume that the primary purpose of these targets is to try to restrain the growth in the volume of services being provided. How would the target restrain growth in volume of services if the physicians do not have some mechanism to control their colleagues' behavior? Is it possible that the effect may be to create an incentive for individual physicians to increase their volume of services on the assumption that others will try to game the system by maximizing volume?

Answer. Physicians could constrain growth of expenditures by reducing services that are of little or no benefit to patients. There is convincing evidence that a significant fraction of services now provided is unnecessary and inappropriate, and many physician societies are already developing practice guidelines to help identify and reduce these services. The Commission recommends that the federal government support substantial increases in clinical effectiveness research to determine which services would benefit patients and which would not, and the development of practice guidelines to help get that information to physicians and their patients. We also need to improve utilization review. The Commission believes that expenditure targets will give the medical community an incentive to increase its support for practice guidelines and better utilization review.

Physicians might increase volume of services in anticipation of decreases in charges from expenditure targets. But that should already be happening, since Congress year after year cuts back on the scheduled update in prevailing charges because Medicare expenditures, particularly on physician services, have increased "too fast." Expenditure targets just formalize this and provide a collective incentive for physicians to work through their organizations to slow expenditure growth.

Question. Physicians often cite the malpractice liability problem as a reason for high volume of service (defensive medicine). Can we expect expenditure targets to work if the physicians do not receive some sort of immunity from malpractice claims based on failure to provide every possible service that might have changed the outcome for the patient?

Answer. Malpractice and defensive medicine are very real problems. Many physician groups have asked the Commission to address them. Fear of malpractice could inhibit attempts to reduce services that have little or no benefit, but which the physician thinks might reduce his chance of being sued. Practice guidelines provide one way combat this problem. Guidelines developed in good faith by the profession may well become accepted as clinical standards by the courts, and protect physicians who practice in accord with them. Further, some of the services that should be reduced provide no benefit, and could cause harm and increased malpractice risk, such as unnecessary surgical procedures. Still, the Commission recognizes the importance of the malpractice problem and the intensity of the concern of the medical profession. We will explore this area in the coming year, and plan to bring to you additional suggestions for reducing the unfortunate effects of medical malpractice on the quality and cost of care.

Question. Is the use of expenditure targets a crude form of rationing of services? If society wants to limit the amount spent on health care, shouldn't a more specific set of limits or criteria be established, rather than just an aggregate limit? How are physicians supposed to make the decisions of which services to provide and which to withhold in the absence of clear practice guidelines?

Answer. If we want to slow expenditure growth without reducing access and quality of care, we have little choice but to identify and reduce specific services and procedures that would not benefit the patient. This requires the medical knowledge that research and practice guidelines provide. Expenditure targets would give the medical profession an incentive to work with Medicare to develop and use this information.

Practice guidelines and parameters are a key to reducing unnecessary and inappropriate services—and to ensuring that patients receive the services they need. The Commission recommends expenditure targets as one of a package of policies to reduce services of little or no benefit to patients. Expenditure targets would be complemented by increased federal support for clinical effectiveness research and practice guidelines to give physicians and patients the information they need to reduce these services. Improvements in utilization and quality review by PROs and carriers would make it more accurate and effective and would complement practice guidelines and expenditure targets.

Question. On a more technical note, if expenditure targets were adopted, how soon would the expenditure data be available to determine whether the target was being exceeded? In the past, annual data on Part B expenditures has not been available until well after the end of the year.

Answer. This is an important question that the Commission has examined carefully and discussed with HCFA, giving attention to the likely capabilities of HCFA's new common working files as well as to existing Medicare data systems. As you point out, data do, indeed, require significant time to become available. That is a major reason the Commission recommends an expenditure target system that bases each annual update of the conversion factor on the preceding year's expenditures rather than a system using withholds that tries to operate in "real time"—say on a calendar quarter by calendar quarter basis.

Our study of the issue indicates an update based on a good estimate of a year's expenditures could go into effect six months after the end of the year. The quality of the estimate would be improved after implementation of the Commission's recommendations on claims: that providers should file claims for all services, including unassigned services; that they should do so within 90 days after the delivery of services; and that electronic claims submission should be fostered. A six month time lag is, incidentally, the same as that now used when Medicare updates prevailing charge and customary charge screens.

Question. The American College of Surgeons proposed a separate expenditure target for surgery. Did the Commission consider the proposition of having separate expenditure targets for different types of services, and if so, why did it reject the proposition?

Answer. The Commission was carrying on technical analyses of separate targets for different types of services before the College's proposal, and the College's testimony in their favor enhanced our interest in them. With such targets the physicians affected and involved in making them work would primarily be in related specialties, with potentially closer working relationships and professional links than the physician community taken as a whole.

The Commission's recommendation for a single national target is not a rejection of separate targets. Rather, it represents a judgment that the best approach, at least initially, is to adopt a very simple, easily understood, and rapidly implementable expenditure target system. We anticipate that the system might evolve into one with multiple targets and have been looking at state-level targets as well as service-related targets.

Our analyses of service-specific targets so far did identify an important problem. It would be very difficult to find objective bases for setting different expenditure growth rate targets for different categories of services. The analyses also suggested that some of the benefits of category-specific expenditure targets might alternatively be obtained through the initiatives on practice guidelines and on utilization and quality review that we recommend.

RESPONSES TO QUESTIONS SUBMITTED BY SENATOR MITCHELL

Question. I am pleased that you and Dr. Hsiao mention the need for more effectiveness research. I believe that patient outcome studies are a critical adjunct to any payment policies aimed at slowing the rate of medical care inflation. But equally important, such research will accommodate an element that is lacking in both the RVS and the fee schedule—that of accounting for quality of care. Would you care to comment on this?

Answer. The Commission believes that increasing clinical effectiveness research and the development and dissemination of practice guidelines is vital if we are to slow expenditure growth without reducing quality of care. Beyond that, there is the potential for improving quality by reducing services that don't benefit the patient but sometimes pose risks, and by ensuring that patients get the services that would substantially benefit them. The Commission recommends that the federal government increase its support for clinical effectiveness research by several hundred million dollars per year, and a fraction of that should be used to develop and disseminate practice guidelines. Both of these initiatives will require increased public support.

Question. I understand your position that you are not advocating mandatory Medicare assignment, but it seems to me that your position to limit beneficiary cost-sharing still has some problems. For example, if the limit on balance billing is set very low, some—maybe many—physicians may stop accepting Medicare payment from their elderly? Is this not possible?

Answer. Our simulations indicate that the effects of balance billing limits on physicians will vary by type of service, and by the mix of services that physicians perform. Even with low ceilings on balance billing, most physicians in the medical specialties would receive higher levels of Medicare compensation under the Medicare Fee Schedule, assuming they perform the same types of services they did under CPR. Clearly, physicians in many surgical specialties would receive less if balance billing were limited. Overall, however, only a about one fourth of physicians would experience reductions of 25 percent or more in Medicare revenues, and of these, some might adjust their practice patterns in ways that reflect the new incentives of the payment system. The magnitude of the reduction will reflect the extent to which physicians bill for visits and consultations —for which payment would increase under the fee schedule— rather than technical services for which payment would decline.

Medicare accounts for only a portion of physicians' incomes, and this proportion varies a great deal across practices and specialties. For some specialties, such as ophthalmology and thoracic surgery, Medicare patients comprise a large proportion of physicians' case loads. It would be unlikely that these physicians would refuse to see elderly patients even if fees were significantly reduced. For many others, Medicare is only a fraction of total practice income (on average, we estimate that about 32 percent of the incomes of physicians who treat any Medicare patients come from Medicare payments) If an "average" surgeon experienced a 10 percent decline in Medicare revenues, this would mean a 3-4 percent decline in income. We do not think many physicians would abandon Medicare patients as a result of reductions of this magnitude.

Finally, it is likely that other payers would follow Medicare's lead and adjust their payment levels accordingly. This would substantially limit incentives to shift to non-Medicare patients.

Question. How would you ensure that the separate liability insurance add-on that you recommend is done fairly, and in a non-inflationary way? To be sure, no one wants to have the government subsidizing the enormous malpractice costs for certain states, yet we want to ensure access to care for pregnant women. How would your proposal balance these concerns?

Answer. The Commission's principal motives to separate liability insurance premiums from other costs in the Medicare Fee Schedule (MFS) are to (1) Pay physicians fairly for practice costs that are incurred, especially costs that are out of their direct control, such as professional liability insurance (PLI), (2) Potentially reduce the complexity of the calculation of the MFS, particularly if the lump sum payment method is chosen, and (3) Increase the visibility of the malpractice and PLI problem.

The current CPR system does not fairly pay physicians for the recent rapid increases in PLI premiums. The only adjustment that can be made in the current system is a single national Medicare Economic Index (MEI) adjustment, which does not reflect the substantial variation in PLI rates by specialty and by state. Any mechanism that does not recognize the costs of PLI, which are completely determined outside of the physician's control and must be paid in order to practice, is not treating physicians equitably. Any of the three methods discussed in the Commission's 1989 report would reduce the inequities of the present system.

A direct payment of PLI premiums by the government is not likely to have significant inflationary impacts on the costs of medical care or liability insurance for several reasons. First, in most states, and perhaps all, the PLI market is not competitive. Physicians have little choice of carriers and rates and are unable to shop for lower premiums. In an uncompetitive market, no incentive exists for physicians to seek lower premiums, and a direct payment of premiums would have no impact on physician ability to obtain lower rates.

Second, some states regulate insurance rates, so markets cannot be competitive. Further, depending on the type of rate regulation, insurers would not be permitted to raise their rates regardless of Medicare's payment policy.

The only way in which such an add-on might have some market impact would be if insurance carriers, seeing a guaranteed increase in payments in the aggregate, increased their premiums. This effect would occur only if states did not regulate carriers, and would be mitigated by the relatively small (20–25%) portion of the premium that would be paid by Medicare.

A third reason that this policy is not likely to be inflationary is that Medicare implicitly already pays the costs of liability premiums, whether they are high or low. Since the amount of the add-on would in the aggregate equal the amount currently spent, any inflationary impact would have to come from the change in the incentives of the payment mechanism, rather than the amount itself. To the extent that there was some change in incentives that was inflationary, it would depend on the market conditions in each state.

The high costs of PLI premiums and defensive medicine are of great concern to the Commission. Given that the cost of the premiums alone is substantial, the Commission will be investigating this area further in the upcoming year. If the costs of malpractice and PLI are to be reduced, it may be necessary for the Federal government to initiate reforms in the liability insurance system.

Question. I am pleased to hear that of the alternative geographic adjusters under study, your proposed method ("overhead only") would minimize the magnitude of geographic variation among physician payments. (Of course, uniform payment would eliminate the disparity altogether.)

I would just like to caution that overhead may not always be much less, or less at all, in rural areas. In some cases, transportation costs and the inability to bulk purchase supplies may cause rural doctors to pay a premium price. I hope that any final geographic adjustment that is developed for overhead pays careful attention to such considerations.

Answer. As you noted, the geographic multiplier proposed by the Commission involves using a single method for determining fees in both urban and rural areas. Overhead costs are reflected in this geographic multiplier by data on prices that physicians face in different areas. There are only three components that vary from one area to another: office rent, wage rates for nonphysician personnel, and malpractice premiums.

The Commission recommends that a uniform policy on defining charge localities to which the geographic multiplier will be applied is needed. It will work in conjunction with HCFA and its Medicare carriers to develop a specific policy in this area.

The Commission heard important testimony about costs of practice in rural areas. For example, rural physicians may need to have more equipment in their offices because they do not have hospitals nearby to conduct tests or, as you described, rural physicians may not have opportunities to purchase supplies in bulk for discounted rates. To get good information on actual costs, the Commission conducted a survey of physicians. Our analysis of the data is just beginning, and we would be happy to share our findings on rural practice costs as soon as the data are ready. If the data show that rural physicians' practice costs need an adjustment to account for their inputs, we would clearly recommend adjusting the multiplier.

RESPONSES TO QUESTIONS SUBMITTED BY SENATOR DURENBERGER

Question. Summarize briefly the Commission's reasons for recommending that Medicare move from a market pricing (charge-based) system to a cost-based system for physician payment.

Answer. In its 1988 report to Congress, the Commission recommended basing the relative value scale for the Medicare Fee Schedule primarily on resource costs. It considered the two major bases for an RVS that appeared most feasible: historical charges and resource costs. The rationale for using what physicians have historically charged is that such charges reflect a market valuation of physicians' services. But the market for physicians' services that are often covered by insurance does not function well, and the resulting pattern of charges reflects serious distortions. Indeed, reducing these distortions is the principal reason the Commission has advocated a fee schedule. A resource-cost basis for the RVS would reflect estimates of what relative values would be under a hypothetical market that functions perfectly.

Under such a market, competition drives relative prices to reflect the relative costs of efficient producers.

Question. Describe the types of data and the frequency and scope of data collection that you expect will be required to support the RVS-based system over the next 3-5 years. What entities will be responsible for these tasks and what is the estimated cost of performing them?

Answer. The availability of accurate, complete and timely data is essential in view of the recommendations being made by the Commission. The data fall into two categories: claims data and survey data.

Claims Data. Claims data represent the primary source of information on utilization and expenditures for purposes of program management and monitoring. The quality and availability of claims data are essential to:

- Monitor access to health care by examining trends in utilization in different regions of the country and in sub-groups of the Medicare population. This information will be incorporated into the annual update of the Medicare Fee Schedule (MFS).
- Calculate physicians' fees, based on actual versus targeted rates of increase in expenditures per enrollee, in the event that a national expenditure target is adopted.
- Support peer review and educational functions that would assist the medical profession in both responding to an expenditure target and improving the quality of care provided to beneficiaries.

In our 1989 Annual Report to Congress, we make the following recommendations to address the shortcomings of the claims data system:

All claims, assigned and unassigned, should be prepared and submitted by providers within 90 days after the delivery of service; and

HCFA should establish comprehensive requirements for carrier electronic claims submission capabilities and provide technical assistance to carriers. This should be accompanied by adequate and predictable funding for the development of carrier electronic media capabilities and a timetable for complete conversion.

There are barriers to the use of electronic claims processing. First there are legislative barriers. These include inadequate appropriations for carrier operations and the imposition of "floors" on processing times. In addition, OBRA 1987 mandated that carriers must hold payment until 14 has elapsed from receipt of a claim. This is a disincentive for carriers to convert to a quicker electronic system. Second, there are administrative and operational barriers due to the absence of established requirements for the development of an electronic system, concern about potentially inadequate procedural requirements, and the costs and complexity of modifying systems.

On the other hand, progress in being made in some areas. For example, HCFA is currently modifying the claims data system to establish a common Part A and B file and plans to install an integrated on-line Medicare and Medicaid administrative data system that will be accessible to HCFA central and regional offices, carriers, intermediaries, and PROs (called PRISM).

Tasks Necessary

HCFA—establish requirements for the development of comprehensive electronic media capabilities; develop a timetable for the complete conversion to electronic media using a slow phase-in; offer technical assistance to carriers; modify carrier contracts and performance evaluations to place greater emphasis on electronic media development and marketing; and work toward a timely completion of the combined A and B files and the PRISM project.

Carriers—increase electronic media capabilities which, in turn would encourage adoption of this method by physicians; and evaluate and disseminate information about software packages to providers and offer benefits, such as prompt payment to the extent of the law, to providers who use electronic claims submission.

Estimates of the costs associated with the use of claims data must take into consideration which activities are simply an extension of current activities, which are new and may require additional start-up funds (even if they are expected to save money over the longer term), and what the impact of more effective use of claims data for monitoring and review will be on both administrative and overall program costs. The Commission has been talking with HCFA staff about these issues and will provide additional information on costs as it is developed.

Survey Data. Survey data can complement claims data in several important ways. Information concerning beneficiaries' self-perceived health status, source of payment for health care, socioeconomic characteristics, levels of disability, and attitudes toward their health care providers would be vital to the administration of a MFS.

The Commission's plan to monitor access to care under a MFS incorporates data from current national surveys (i.e. the Health Interview Survey) Baseline and trend statistics can be collected to monitor changes that may occur after a MFS is adopted.

Currently, there is no single survey of Medicare beneficiaries that can monitor the impact of program changes. The Commission recommends that the recently proposed Current Beneficiary Survey (CBS) be developed and fielded. By design, this survey has the potential to overcome the major drawback associated with surveys—lack of timeliness. The CBS could serve PPRC, HCFA and others in their work to estimate the costs of legislative proposals, to develop national cost estimates for health care, and to study the role of supplemental insurance (medigap). The Commission and HCFA may also conduct smaller, targeted surveys of population groups or geographic regions on issues identified in program monitoring.

The projected cost associated with a comprehensive set of survey data is not known at this time. The proposed CBS has been priced at $6.6 million to start up and $5.4 million annually if performed on a monthly basis, however there are several options available.

Question. Physician payment methodologies are an important component of expenditures for capitated or other prepaid health services. What is the Commission's planned scope of work in this area currently and do you plan to expand it? If not, why not?

Answer. The Commission is planning additional work on how to improve contracting between Medicare and HMOs and CMPs. Having addressed issues of risk sharing within prepaid health plans and mechanisms for quality review, we plan to return to our work on the payment mechanism. One task is to assess the current state of research on how to make the AAPCC better reflect the expected medical needs of beneficiaries. Use of practical measures of health status in the payment formula appears to be a promising path. We also plan to consider the merits of formulas by which Medicare would share risk with the prepaid plans. For example, through Medicare provision of reinsurance, windfall gains and losses by plans that result from adverse selection could be reduced. On balance, this reduction of risk could make Medicare risk contracting more attractive to prepaid plans. In view of your long-term interest in capitation issues, I would hope to discuss this and other work that has been planned with you so as to better focus our work on the issues that are of highest priority.

Question. What process will be followed in order to price new procedures under the RVS-based system? Correspondingly, what process will be followed to adjust payment levels for ineffective or obsolete procedures/therapies?

Answer. Once a Medicare Fee Schedule is implemented, it must be updated to take into account a number of factors including changes in technology, the introduction of new services and procedures, and other changes in medical practice. The Commission recommends that the process used to develop the Medicare Fee Schedule be used for updating it as well. Congress would set policy regarding changes in relative values based on information and advice from the Commission. Groups representing physicians, beneficiaries and others would participate in both technical refinements and major policy decisions, with the Commission providing a principal forum for their input. HCFA would continue to be the primary implementing agency carrying out the policies set by Congress.

Revisions in the RVS must be grounded in data and refined by professional judgments of physicians to insure that they do not undermine the use of resource costs as the basis for the fee schedule. This will entail targeted data collection related to physician work and practice costs to supplement existing information, refinements in methods for incorporating data into the RVS, consultation by the Commission with organizations representing physicians, and the use of consensus panels (like that used by the Commission to develop its coding policy for surgical global services) to review the reasonableness of the data and to assure that policy decisions are clinically relevant.

Question. With respect to unassigned claims, what upper limit do you recommend be imposed on physicians' ability to balance bill beneficiaries?

Answer. The Commission simulated charge limits of 115, 120, and 125 percent because limits in this range have already been applied to specified Medicare services. In the Omnibus Budget Reconciliation Acts of 1986 and 1987 (OBRA86 and OBRA87; P.L. 99-509 and P.L.100-203) Congress imposed specific limits on actual charges for procedures whose prevailing charges were reduced because the procedures were considered to be overvalued by Medicare. Currently, charges may not exceed 125 percent of the reduced prevailing charge. Actual charges for services provided by radiologists will be limited to 125 percent of the new radiology fee schedule amount in 1989; 120 percent in 1990; and 115 percent in 1991.

Question. On what basis, other than concern for political consensus building, does the Commission base its recommendation to not require mandatory assignment?

Answer. The Commission has concluded that fixed limits on balance billing are necessary. The market for physicians' services does not function well enough to preclude the need for financial protection for Medicare beneficiaries. Without limits on balance billing, beneficiary costs would increase and access to care could suffer. However, the Commission recognizes that the fee schedule has been designed to compensate physicians for the typical or representative costs of providing services or procedures. It cannot always reflect the complexity or difficulty involved in treating specific cases. While the overall compensation to most physicians under a resource based fee schedule is designed to be fair and adequate, some provision for balance billing could provide a "safety valve" for physicians who believe that the fee schedule payment does not adequately reflect the quality of services they provide. In the absence of such a safety valve, beneficiary access to care could be reduced. In addition, no matter how much care is taken in developing the fee schedule, there will be instances where errors occur, or where sudden changes in technology lead to increases in the costs of performing procedures that can not be immediately incorporated into the fee schedule.

Question. Given the data bases available to the Commission, what proportion of Medicare payments are attributable to practice costs, on average, by the thirteen specialty categories identified in Table 2 of Dr. Lee's March 17th testimony?

Dr. Lee: The proportion of Medicare payments attributable to practice costs is as follows:

	Percent
Internal Medicine	48
Family Practice	59
Dermatology	46
Ophthalmology	48
General Surgery	42
Orthopedic Surgery	50
Urology	48
Thoracic Surgery	43
Otolaryngology	51
Ob/Gyn	51
Radiology	44
Pathology	32
Anesthesia	38
Other	46
All Physicians	47

RESPONSES TO QUESTIONS SUBMITTED BY SENATOR PACKWOOD

Question. In your testimony, you summarize the results of simulations using a fee schedule based on a resource-based relative value scale, reporting the likely impact on beneficiaries' out-of-pocket costs (coinsurance and balance billing), grouped by age, sex and so on.

I am interested in the impact on a particular subset of beneficiaries: the older person in rural parts of my state who makes lots of visits to his or her family physician but who does not require hospitalizations or surgical procedures. Isn't it likely that this person's out-of-pocket costs will increase? What do your simulations show for this kind of patient?

Answer. Overall, out-of-pocket expenses for beneficiaries living in rural areas will probably decline under the Medicare Fee Schedule, even for those patients who do not require hospitalization or surgery. Coinsurance payments for physicians' visits will, as you suspect, increase, but only by small amounts. For example, we estimate that the average changes in coinsurance for an intermediate office visit would rise from $5.60 to $7.06. However, since Medicare payments for office visits will increase, there should be considerably less balance billing for office visits. Since beneficiaries are liable for the full amount of balance billing, compared to 20 percent of increased payments toward coinsurance, they will, overall, pay less under the fee schedule.

The individual exceptions will be those beneficiaries whose physicians are currently willing to accept assignment on Medicare's low reimbursement for office visits.

It is also important to note that most beneficiaries do not have only office visit expenses. Their visits involve tests, such as EKGs, for which payments under the fee schedule will in many cases be reduced. The coinsurance for a beneficiary with an intermediate office visit and an EKG would be $12.58 under the current system, and $11.98 under the Medicare Fee Schedule. Therefore, it is likely that in many instances, beneficiaries' coinsurance for the complete range of services provided in physicians' offices will actually decrease.

Question. Your Table 4 gives the impression that everyone would have a lower bill under the new system. How can this be? What are the characteristics of the subgroups whose costs would increase?

Answer. The decreases in combined coinsurance and balance billing payments shown in Table 4 reflect the large impact of the Commissions's proposed charge limits on beneficiary balance billing liability. Because balance billing is concentrated among a relatively small proportion of beneficiaries, and some of these balance bills are very large, limiting charges to 125 percent of the fee schedule amount reduces average beneficiary balance billing liability by more than half its current levels. Some of this effect is countered by small increases in coinsurance for services for which payment is increased under the fee schedule, but because balance bills account for almost 40 percent of the combined expenses, there is a reduction in liability for every beneficiary group. If there were no limit on charges, balance billing liability (and combined out-of-pocket expenses) would increase across the board. The greatest increases, without a balance billing limit, would be among beneficiaries who were hospitalized, and beneficiaries in small rural areas.

As was noted in the response to the preceding question, it is unlikely that most beneficiaries would use a mix of services that would lead to a net increase in out-of-pocket costs under the fee schedule with limits on charges for unassigned claims. Beneficiaries in small rural areas may experience some increase in coinsurance, but these costs would in most cases be offset by reduced costs for in-office procedures and tests, and in some cases by significant reductions in the costs of surgery or inpatient care.

Question. What aspects of your proposed changes in paying physicians (e.g., expenditure targets, caps on balance billing, fee schedule payments) contribute most to the reductions or increases in beneficiary out-of-pocket costs?

Answer. In the short run, the limits on balance billing proposed by the Commission would be the greatest contributor to the reduction in beneficiary out-of-pocket costs. Coinsurance remains on average very similar to that under CPR for most beneficiaries. In the long run, however, expenditure targets would decrease the rate of growth in beneficiary costs by controlling increases in both premiums and coinsurance.

Question. In characterizing overhead costs for physicians, there seems to be an assumption that all physicians performing the same services can be expected to have similar overheads, except perhaps for area differences. One of the important ways for physicians to reduce their overhead costs is to form group practices.

Do you anticipate that the changes you propose will favor physicians in such arrangements? Please explain how they will or how they won't.

Answer. Physicians may form group practices for a variety of reasons: to reduce costs, to increase personal convenience, or to work more closely with colleagues. However, the nominal costs of running a practice are probably not the most important factor in the decision to form groups. For example, in nominal terms, group practices tend to have higher costs than solo practices. The likely explanation for this is that they offer more services, or make practicing medicine a little more comfortable for physicians and their employees.

Group practices probably offer a wider array of services than solo practices, such as diagnostic services, which contribute to both practice costs, as well as physician net income. In fact, incomes tend to be higher for physicians who work in groups.

While practice costs and incomes differ by group size, both solo and group physicians may still be operating efficiently. While solo physicians may be able to join groups and increase their net incomes, they may have other reasons for not doing so, or may not practice the type of medicine that would be most compatible with joining a group.

It is difficult to determine whether the adoption of the MFS will adversely impact solo physicians. Under the current system, all physicians are paid without consideration of their group status, so to the extent that the physicians in groups are already benefiting from their group status, they will continue to do so.

On the other hand, overhead costs in the MFS are calculated as averages that may incorporate the costs of services not provided by solo physicians, such as the additional equipment and space required for certain diagnostic facilities. Physicians not providing those services will nonetheless receive a small amount of extra payment because they will fall below the average. Conversely, a large group with costs well above average may not receive quite enough to cover its capital costs, unless it has achieved substantial economies of scale.

A thorough analysis of whether any reimbursement system favors group or solo physicians would have to take into account the services provided by each, the effects of changes in payment on access, and in short, the overall worth of the medical services provided. Given that there are reasons other than the efficiency or costs of the individual groups to maintain different size practices with different practice styles, it may be inadvisable, for example, to reimburse solo physicians at a high enough rate to provide all the services that are available at large groups.

Question. Could doctors in rural areas—for example, where there are fewer opportunities for forming large group practices—be at a disadvantage in the way overhead is taken into account?

Answer. The points I made in my previous answer also apply in this case. In a rural area, most physicians probably cannot make available the same scope of services that is available in an urban setting. Rural physicians also spend more hours working, more time seeing patients outside of normal working hours, and probably have less flexibility in scheduling another physician to take their place while they take time off.

The interaction between physician productivity, access to various services, and payment is a complex one, and the lower opportunity of physicians to form groups in rural areas certainly has an impact on the way in which services are delivered. However, if we do not expect solo physicians to provide all of the services provided at, for example, a large multispecialty group practice, then a rural physician practicing efficiently should not be adversely impacted by a payment system that provides overhead payments that are based on system averages.

Question. If Congress is unable or unwilling to implement all of the changes you propose, which ones would be the most important to implement and why? In assessing importance, please include an estimate of their impact on total Part B costs.

Answer. Certainly the various elements of the package of proposals that the Commission has recommended could be pursued separately. For example, either a fee schedule or expenditure targets could be enacted without the other. But the Commission found in its deliberations that the combination of proposals was especially attractive. The Commission was unanimous in its support of the proposals that were described in my prepared statement, except that four members thought that we should have gone further in restricting balance billing. They filed a minority report in support of mandatory assignment. I felt that separate pieces of the package would not have gotten the support that the entire package received. For example, some might object to enacting a fee schedule without simultaneously putting into place a policy to curb the growth in spending, while others might object to expenditure targets in the absence of a policy to address the distortions in relative payments. On the other hand, increased funding for effectiveness research and practice guidelines could be pursued either with or without the payment reforms.

Question. How do you respond to concerns that the new RBRVS, if implemented, could result in increased expenditures, even if constructed in a budget neutral fashion? Under what circumstances would increases occur and under what time frame? (Consider, for example, costs associated with the start-up and continued administration, monitoring, and updating of the RBRVS fee schedule.)

Answer. The major uncertainty concerning the effect of a Medicare fee schedule on expenditures concerns the impact on the volume of services. Changes in fees for physician services will induce changes in the volume of services. These changes may be symmetric in the sense that changes in volume for services for which fees have increased offset changes for services for which fees have decreased. In that case, expenditures would be unchanged. However, some suggest that effects of decreases would be of larger magnitude than effects of increases. Unfortunately, the research literature on the effects of changes in relative values on the volume of services is not extensive and not conclusive.

This uncertainty about induced changes in volume can be dealt with in two ways. First, whatever those who project costs feel they know about the net effects on volume can be incorporated into the conversion factor. If they are right, then the fee schedule would be budget neutral in the dynamic sense—after induced changes in volume. Second, expenditure targets would automatically correct for unexpected changes in volume induced by the fee schedule. Thus, if volume increased by 1 percent more than expected, the following year's conversion factor would increase 1 percent less than otherwise to compensate. This could be accomplished either by the permanent expenditure target that the Commission is recommending or by a temporary mechanism used only to correct for errors in budget projections for the fee schedule.

Turning to administrative costs, the fee schedule would reduce administrative costs. Under current law, carriers must maintain a profile for each physician and calculate customary charge screens and MAAC limits. This process is expensive and subject to error. It would not be needed under a fee schedule. While I do not have an estimate of start-up costs, I doubt that they would be large. They probably would be less than the first year savings from no longer maintaining profiles of physicians. The costs of monitoring and updating would be measured in millions, compared to hundreds of millions for administration and tens of billions in payments to physicians. Much of the monitoring activities would probably (and should) be pursued whether or not we have a fee schedule.

RESPONSES TO QUESTIONS SUBMITTED BY SENATOR CHAFEE

Question. You have given us some recommendations as to how we might implement a resource-based fee schedule as the new Part B reimbursement system. Those recommendations strike me as good, sound policy, and I'm impressed by the thoroughness of the work which supports them.

My fear is that the beauty of this proposal—its rationality, its internal consistency—will be lost somewhere in the legislative process. In that vein, perhaps you could give us some reverse recommendations: that is, can you foresee any pitfalls we should be careful to avoid as we attempt to translate these proposals into legislation? I'm thinking of policies that the Commission may have considered and rejected, or believes have the potential for defeating the purpose of the entire exercise.

Answer. The annual report that the Commission will be submitting to Congress at the end of April will be very comprehensive in its discussion of how it reached its recommendations. These discussions indicate what the alternatives were and the reasoning behind the decisions taken by the Commission. Repeating all of that discussion in this forum would not be feasible.

There is, however, one general observation that I can make concerning what *not* to do. It is important that payment reforms be acceptable to beneficiaries and physicians. One of the requirements for acceptability is that the process that developed the parameters of payment be viewed as an objective process. Thus, if relative values of services are to be realigned, the methods used to develop the new relative values must be understood. Any modifications from the values presented in the Commission's report should be based on either additional data or the judgment of experts.

Question. This question is beyond the scope of the task given to the PPRC: you were charged with analyzing a resource-based fee schedule and you have done that admirably. But since you have clearly given so much thought to the issue of cost control, I wonder if you have any views as to how we might handle the problem of malpractice liability, a major contributor to costs? Under a fee schedule, we would still have the same basic problem of physicians practicing defensive medicine. How might we deal with malpractice in a more reasonable manner?

Answer. Malpractice and defensive medicine are very real problems. Many physician groups have asked the Commission to address them. Fear of malpractice could inhibit attempts to reduce services that have little or no benefit, but which the physician thinks might reduce his chance of being sued. Practice guidelines provide one way combat this problem. Guidelines developed in good faith by the profession may well become accepted as clinical standards by the courts, and protect physicians who practice in accord with them. Further, some of the services that should be reduced provide no benefit, and could cause harm and increased malpractice risk, such as unnecessary surgical procedures. Still, the Commission recognizes the importance of the malpractice problem and the intensity of the concern of the medical profession. We will explore this area in the coming year, and plan to bring to you additional suggestions for reducing the unfortunate effects of medical malpractice on the quality and cost of care.

Question. Contrary to the expectations of many, your Commission has not come up with a recommendation for mandatory assignment. I am interested in the thinking that led you to the conclusion that mandatory assignment is not the way to go.

Answer. The Commission has concluded that fixed limits on balance billing are necessary. The market for physicians' services does not function well enough to preclude the need for financial protection for Medicare beneficiaries. Without limits on balance billing, beneficiary costs would increase and access to care could suffer. However, the Commission recognizes that the fee schedule has been designed to compensate physicians for the typical or representative costs of providing services or procedures. It cannot always reflect the complexity or difficulty involved in treating specific cases. While the overall compensation to most physicians under a resource based fee schedule is designed to be fair and adequate, some provision for balance billing could provide a "safety valve" for physicians who believe that the fee schedule payment does not adequately reflect the quality of services they provide. In the absence of such a safety valve, beneficiary access to care could be reduced. In addition, no matter how much care is taken in developing the fee schedule, there will be instances where errors occur, or where sudden changes in technology lead to increases in the costs of performing procedures that can not be immediately incorporated into the fee schedule.

Question. The PPRC recommends that we set an expenditure target for physician payments under the proposed fee schedule—starting out with a national target, and then perhaps moving to sub-national targets. Presumably, if a target wasn't met in any given year, then the fee schedule for the doctors in that group would be reduced, or increased at a slower rate. How, under this arrangement, do we avoid a situation where Doctor A, who has relatively less expensive patterns of practice, ends up bearing the burden for Doctor B's relatively more expensive patterns of practice?

Answer. The expenditure target system is designed to slow the growth of expenditures by reducing unnecessary and inappropriate services through physician education and peer review. If a physician were using a more expensive pattern of practice because he provides many unnecessary and inappropriate services, then his practices would be the focus of educational programs by his peers and of utilization review by PROs and carriers. Success in reducing these services would slow expenditure growth to the target, and all physicians would receive increases in their fees. If the expenditure target is not met, all physicians would receive a smaller increase in fees. It is important that the incentive to reduce unnecessary services apply to all physicians, even those who have a relatively less expensive pattern of practice. Medicare needs for all physicians to help in the design of practice guidelines and better criteria for utilization review, and to help educate their peers about the most cost-effective ways to care for patients. Every physician could improve, even those with less expensive practice patterns. This policy is designed to motivate the medical community to pull together to do what must be done to slow growth in expenditures without reducing quality and access to care.

Question. Can you tell us how what is proposed here compares to the Canadian system?

Answer. Most of the Canadian provinces build in some "feedback" of rising expenditures to physician fees. In some provinces, the government insists on smaller increases in fees at negotiations with the physicians if expenditures have been rising rapidly. This is somewhat like what Congress has done in the U.S.: prevailing charges for physician services are increased by less than the Medicare Economic Index because Part B expenditures have grown too rapidly. In several Canadian provinces, the feedback takes the more structured form of an expenditure target somewhat like that proposed by PPRC. The increases in physician fees depend on the previous year's rate of expenditure growth according to a formula. In Canada as under the PPRC proposal for the U.S., it is intended that the medical profession will go to work to slow growth in the utilization of services.

The Commission does *not* recommend a path taken in one Canadian province, Quebec, in which ceilings are placed on the incomes physicians can earn.

RESPONSES TO QUESTIONS SUBMITTED BY SENATOR HEINZ

Question. You argue that we should implement a Medicare fee schedule on a cost neutral basis in FY90 to facilitate implementation and acceptance by the medical community. While I appreciate your concern here, the reality is that we may have to find Medicare savings somewhere between the G-R-H sequestration level of $1.2 billion and the President's $5.1 billion.

I have two related questions. First, where do we believe savings could be found in Part B that would not undermine the start-up of RVS in FY90? Second, what effect would the cuts in the President's budget have on our ability to implement RVS next year?

Answer. When the Commission speaks of the initial conversion factor of the fee schedule as "budget neutral", it does not mean to imply that budget savings cannot be achieved during the period in which the fee schedule was implemented. It just considers the fee schedule, which it views as fundamental reform, separately from the need to meet budget objectives in the short term.

There are a number of mechanisms to meet budget targets that would not be inconsistent with implementing a Medicare Fee Schedule. For example, the update in the Medicare Economic Index (MEI) could be delayed or reduced. When the conversion factor for the initial stage of fee schedule transition was calculated, it would use this reduced baseline. There certainly are additional alternatives, but the Commission has not to date received any requests for advice on the Fiscal Year 1990 budget targets and, as a result, has not yet focused on these issues in any detail.

I do have a point concerning the option of "overpriced procedures". When the Commission recommended this in 1987, it gathered all of the information that it could to determine which procedures appeared to be out of line. In 1989, with the Hsiao study and the analysis by the Commission to develop the fee schedule proposal, a great deal of additional information is available. Thus, whether the Congress chooses to begin the implementation of a fee schedule or instead opts for a series of short-term steps, such as "overpriced procedures", each approach should be based on this expanded base of information.

Question. If there is one thing the specialists and primary care providers agree on it's that they oppose the very notion of expenditure targets. Given this, how can we possibly expect to get support for RVS if an expenditure target is attached?

Answer. The Commission recommends expenditure targets because it has concluded that we must slow the rate of expenditure growth, and that expenditure targets are the best way to accomplish this for Medicare. The Commission also recommends substantial increases in federal support for clinical effectiveness research and practice guidelines so that the expenditure targets can be met by reducing services of little or no benefit to patients. A number of medical groups *do* support expenditure targets: the American College of Surgeons (ACS) has proposed an expenditure target for surgical services, and a number of surgical specialty societies have testified to the Commission that they endorse the position of the ACS.

The Commission has spent more than a year studying expenditure targets and developing its proposal to Congress. As others in the medical community study the proposal, they may understand why the Commission has concluded that it is the best alternative we now have for slowing expenditure growth in Medicare.

Question. I fully agree that outcomes research and practice guidelines are the key to improving medical practice and controlling costs. Where do you think our research is strong enough to begin developing guidelines now? Where should we begin and when might we see savings? How much money should we invest in research and guidelines development?

Answer. Guidelines can be developed right now for most of the major medical and surgical procedures using the research we have already done and the expertise of practicing physicians. In fact, researchers at the RAND Corporation and several medical specialty societies have already done so, and others medical societies have begun to develop guidelines. We need to begin as soon as we can to build on these private sector efforts with public coordination, funding, and oversight. Leading members of the medical profession, perhaps convened by the Institute of Medicine, could help set priorities for which procedures to start with. Guidelines could be developed and put to use in a very short time, perhaps as soon as a year, once the funding is secured. The Commission recommends that the federal support for clinical effectiveness research be increased by several hundred million dollars per year, and tens of millions per year go for development, dissemination, evaluation, and revision of practice guidelines.

Question. One concern I have with the notion of expenditure targets is the potential incentives for physicians to simply turn sicker patients away that would incur higher Medicare costs—a problem we've seen with HMOs. Is this a valid concern and why?

Answer. Unlike HMOs, expenditure targets do not give an individual physician a financial incentive to provide fewer services to any patient, or to choose not to care for sicker patients. An individual physician is not at financial risk for the costs of the services he provides his patients because those costs have an infinitesimal effect on the fees that physician would be paid in the future. Physicians would still be paid on a fee-for-service basis, so they would have the same incentives to do more and be paid more. The expenditure target would work through their collective incentive to the whole medical profession to work through their leadership and organizations to reduce expenditures. For instance, they could develop and disseminate practice guidelines, as a number of medical specialty societies have already begun to do. They could also work with the Medicare program to improve the accuracy and effectiveness of PRO and carrier review designed to reduce unnecessary services.

Question. If the Administration were testifying today, I expect they would (a) argue the merits of other approaches to payment such as capitation and further incentives for primary care doctors and (b) argue that your timeframe for implementation is totally unrealistic. How would you respond?

Answer. The Commission carefully considered different options for reform of physician payment two and a half years ago and concluded that for the foreseeable future, fee for service would remain the dominant form of practice for physicians, including those providing services to Medicare beneficiaries. Currently, only about 3 percent of Medicare beneficiaries are enrolled in HMOs. While the Commission supports maintaining the HMO option for beneficiaries, it is premature to consider extensive use of capitation to replace the existing payment method. For this reason, the Commission is recommending moving to a fee schedule. At the same time, the Commission is planning additional work on how to improve contracting between Medicare and HMOs and CMPs, looking at such issues as risk sharing within prepaid health plans, mechanisms for quality review, and methods to make the AAPCC better reflect the expected medical needs of beneficiaries. Improvements in each of these areas could make Medicare risk contracting more attractive to prepaid plans and expand the role of capitation in the Medicare program.

In response to your second point about the timeframe for implementing the fee schedule, the Commission has discussed its schedule with key staff in both the Congress and the Health Care Financing Administration and believes that its implementation schedule, while ambitious, is realistic. The information exists to write the specifications of the fee schedule policy into legislation in sufficient detail so that the transition phase of the policy can be implemented shortly after enactment. The transition is structured to incorporate refined data and administrative policy changes as they are developed in a manner that will not cause unnecessary duplication or disruption of carrier activities. Additional work that must be conducted to refine the relative value scale of the fee schedule is already underway and will be completed well before full implementation of the fee schedule. The Commission has been working collaboratively with HCFA to work out the details of the implementation plan.

Question. Your testimony mentions the need to improve our utilization and quality review systems for physician services— which are particularly weak in non-hospital settings. Yet, the PROs and carriers both claim that they are the best person for the quality review job. Who, in your view, should get the job and do you believe it might be worth investing in some demonstrations to find out.

Answer. The reforms we have called for would make use of the skills and resources of both carriers and PROs. Effective quality and utilization review will require close coordination of carriers and PROs in the development of screens to be applied to billing data, and in the development of consistent review criteria. We also have called for HCFA to work with carriers and PROs to plan a way to involve both organizations in a structured medical peer review process, based on the application of professionally recognized standards and criteria, to make determinations about (1) the necessity, appropriateness and quality of physician services in all settings, and (2) the ability of individual practitioners to meet professional standards.

We think that creating a comprehensive medical review program for part B services would require some basic changes in PRO and carrier operations, and we recognize that this will take time. Some pilot projects HCFA has initiated with carriers and PROs—including one project in which carrier medical review responsibilities have been contracted to a private utilization review organization that employs more medical personnel than a typical carrier—are very important. In our report, we discuss options for coordinating PRO and carrier responsibilities for reviewing quality and utilization of physician services. We believe, however, that the PROs, carriers, and HCFA will need some time to work through some complicated administrative and operational issues as well as difficult conceptual problems before they are ready to propose specific approaches for demonstrations.

PREPARED STATEMENT OF EDWIN P. MAYNARD

The American College of Physicians appreciates this opportunity to present the views of physicians in internal medicine and its subspecialties on the Resource-Based Relative Value Scale (RBRVS). With a membership of 65,000 general internists and subspecialists, the College is the largest medical specialty society in the country. I am Dr. Edwin P. Maynard, President of the College and an internist in practice at the Massachusetts General Hospital.

Introduction

Mr. Chairman, before we address the specific issues of the relative value scale, it will be useful to recall briefly the history of third party payment for medical services. It is important to remember that the first insurance, provided through the Blue Cross/Blue Shield companies, was established to provide coverage for hospital care. Services in physicians' offices were not covered. When these were later added, payment rates were set at low levels compared to the surgical services which were the primary focus of these policies.

When Medicare was established in 1965, Congress agreed to a payment system that would reflect prevailing charge patterns, in order to overcome physician opposition to the program. Thus, the undervaluing of primary care from the Blue Cross/Blue Shield experience was mirrored in the Medicare program. The disparities worsened over the years: new procedures were developed and payments for them reflected the charge patterns of the physicians pioneering the technology; at the same time, the basic cognitive work of the physician—the office and hospital visit and consultative services—did not change substantively and there was little opportunity for these physicians to set new charge patterns.

In simplified fashion, this explains much of the inflationary spiral of Medicare's history: new procedures developed, fees set at initially high levels and never reduced, little chance to update fees for cognitive services, more and more pressure to perform more and more procedures, and little information on appropriate levels of service. The Congress has attempted to respond to this spiral through a variety of initiatives to restrain spending growth and its effects. You have placed limits on fees as a percent of prevailing charges, limited increases to the Medicare Economic Index (MEI), frozen and limited the MEI, created the participating physician program, and placed limits on actual charges.

The result of all this tinkering has been to create a nightmarishly complex set of rules and distortions in the system, but there has been little impact on costs. Further tinkering will not work. The basic system of customary, prevailing and reasonable (CPR) payments must be replaced. The system is inflationary. Out-of-pocket costs become an increasingly greater burden to the beneficiary, and program costs to the taxpayer rise by double-digit percentages annually. The CPR system provides inappropriate incentives for physicians' choices about what services to provide. It favors the inpatient setting over outpatient alternatives. It favors urban and suburban areas over rural areas. It encourages over-specialization. It is extraordinarily difficult for providers and patients, and even program managers, to understand and cope with.

Recognizing these weaknesses of the CPR system, Congress directed the Health Care Financing Administration (HCFA) to undertake research which would permit Medicare to move to a payment system based on an objective measure of the relative value of physicians' work. Congress also had the foresight to create its own advisory panel for analysis and recommendations on these issues, and it can now call upon the expertise and wisdom of the Physician Payment Review Commission (PPRC) in developing legislation. Few, if any, similar blue-ribbon commissions have contributed so much to public policy debate in any area as has this Commission, and we commend Chairman Lee and all the members for their 1989 recommendations.

The Resource-Based Relative Value Scale

We now have the initial research results from the Harvard study, as well as the refinements suggested by the PPRC. For the first time, we have an objective measure which can be used to set Medicare payments. We have a measure that reflects the resources consumed to provide medical services.

This is intuitively an attractive concept: prices which are set to reflect the work and other resources that go into providing a product or service. With the use of such a measure, payments for all services will be established in correct proportion to the resources consumed, so that the payment system does not have incentives that favor certain procedures and services over others. This kind of payment system would provide, in Dr. Hsiao's words, a level playing field.

According to the Harvard analysis, the physician's professional work is about half of the resources used in medical services. Measuring work was the major research problem facing the Harvard team, and their solution to that problem is the strongest and most important contribution of their study. They conceptualized work as time multiplied by intensity, and measured several dimensions of intensity in a large survey of physicians, using the technique of magnitude estimation. Dr. Hsiao and his colleagues present careful and convincing evidence that the survey of physicians to generate relative ratings of time and intensity for different clinical services has produced a set of values which were obtained by a reliable. method and are reproducible, and which have a high degree of internal consistency and validity.

After intensive scrutiny, no one has found major flaws in the core of the Harvard work—the development of an objectively measured scale of relative values. Those problems which have been identified—for example, the measurement of practice costs, coding inconsistencies for evaluation and management services, measurement of pre- and post-service work, specific problems for certain specialties—are being addressed by the Harvard researchers, the PPRC, and HCFA, and are expected to be resolved before implementation of a new fee schedule.

With the Harvard and PPRC results, there no longer can be any doubt that Medicare payments under the CPR rules have been based on factors other than the work involved, and that the rules favor high technology medicine over evaluation and management services. This committee has the opportunity to provide critical leadership in enacting payment reform to develop a rational and equitable system that corrects the failures of CPR. We urge you to enact legislation this year to incorporate the RBRVS into a Medicare fee schedule.

Implications for Patient Care

We have heard it said that the RBRVS is simply a means of redistributing Medicare revenues among different types of physicians, so why should Congress be interested in carving up the same pie in a different way? We think you should reject this line of argument immediately. The RBRVS has profound implications for patient care. It may also have important implications for the size of that pie.

The American College of Physicians has long argued that the profession must assure that services to a patient are necessary and appropriate. The payment system has worked against this. By favoring high technology procedures and the inpatient setting over evaluation and management services and other settings, the payment rules have influenced clinical decisions. Especially in cases where clinically the choice of therapies may not be clear-cut, the CPR system has rewarded physicians for performing procedures rather than spending time analyzing, evaluating, diagnosing, and managing the patient's problem. It has thereby influenced physicians' medical choices.

By setting payments for all services in correct proportion to the resources and work involved, the RBRVS neutralizes the influence of the payment rules on the choice of therapy. Incentives are eliminated which lead to medical decisions influenced by factors other than the necessity and appropriateness of the service. This is the right environment for providing optimal care for patients. It is also an environment which may help relieve the upward pressure on the volume of services, particularly the procedural services.

Secondly, an RBRVS-based fee schedule will highly simplify the payment system, so that patients will know in advance from the fee schedule what Medicare will pay for a service. That payment will be the same for all physicians in an area—in sharp contrast to the present situation. The patient's anticipated out-of-pocket expenses will be clear, and that will help the patient decide whether he or she wants to request assignment.

Finally, the payment system appears to have a strong influence on physician choice of specialty. We must worry about access to internists and other primary care physicians, particularly in the next century as the elderly population swells. Medical graduates today are choosing highly remunerative specialties, and staying away from primary care specialties. The RBRVS can play a role in redressing this imbalance, by assuring the prospective internist that he or she will be compensated in the same proportion to the work involved as are all other specialists.

For all these reasons, Mr. Chairman—time with patients, prudent management, simplified payments, and access to primary care—we would argue that the RBRVS is good for patients, and much more than simply a shifting around of Medicare dollars.

In the remainder of our testimony, we would like to discuss a number of major questions that are addressed in the PPRC recommendations. These are issues that will be central to implementation of an RBRVS-based payment system.

Geographic Differential

We support the PPRC recommendation that the fee schedule should vary geographically to reflect overhead costs. Clearly, variations in the costs of practice are a critical adjustment that must be made in creating a fee schedule that is fair to physicians in different practice settings and in different parts of the country. It is consistent with a payment measure rooted in the resources consumed in providing medical services. We support a separate accounting of liability insurance expenses, so that the formula can be sensitive to the volatile nature of these costs and the wide differences in premiums among specialties and from one area to another.

We agree with the PPRC that an adjustment for earnings in addition to overhead is not consistent with the concept of a *resource*-based scale. We do not know why people locate where they do, what they value in an area, or how to turn that value into a monetary adjustment. Additionally, an adjustment which favors very large metropolitan areas may provide an incentive that runs counter to the existing policy goal of easing shortages of physicians in rural and other under-served areas and thereby enhancing access.

Having stated that as a matter of policy, however, we think that caution is well-advised in this area. There will be relatively large shifts in payments to physicians on the basis of relative value scores alone. If at the same time we eliminate the differentials among areas that are part of the CPR system—which reflects both overhead and earnings—the cumulative impact of these various shifts could lead to problems of access or decreases in assignment rates. Policy recommendations and the timing of changes must be sensitive to these potential effects.

Assignment

The PPRC has produced excellent research on the issue of assignment and balance billing. The Commission has elucidated the subtleties of assignment policy and its impacts, and their studies make the point that all-or-nothing proposals on either side of this issue probably are too simplistic. The studies may point the way to alternatives around which a consensus might be formed. The conclusions we draw, however, go beyond those reached by the Commission.

The PPRC studies show that more than half of Medicare patients face no balance bill at all, and fully 80 percent have balance bills of no more than $50. With the steady increase in assignment rates, these percentages may be even higher today. The heaviest burden falls on a relatively small number of patients who are hit in three ways: they need a lot of care, they rarely get assigned care, and their balance bills are high in relation to Medicare's approved charge. In addition, balance billing differs among specialties and, to some extent, among types of service, and appears to increase with more expensive services.

With assignment rates approaching 80 percent, and large balance bills falling on a very narrow band of patients, the data indicate that across-the-board mandatory assignment is not necessary, and the College opposes this option. Physicians have obviously concluded that, in the large majority of cases, the Medicare payment should be accepted as payment in full. Second, why should a Medicare patient who can afford to pay the physician's customary charge be treated differently from a private-pay patient or one who must pay a balance because his private insurance company's rates are less than the full charge? Third, even under the RBRVS, Medicare is expected to pay below the market in most cases. With the pressures on the federal budget, over the long-run a Medicare fee schedule may fall significantly below reimbursements made by other insurers. The retention of appropriate balance billing provides an assurance to providers if the gap between the market and Medicare becomes excessive.

The College believes there are two key elements to a reasonable policy on assignment. The first is to protect people who cannot afford the balance bill. The second is that assignment policy should be uniform. That is, it should be set by the government as the agent of society, not by physicians on an ad hoc basis. Our current system forces the patient to request assignment or forces the physician to depend on a person's clothing or address as clues to his or her financial status. This system allows two people of the same income status to be treated differently in two different doctors' offices, and that is simply not equitable.

Again, the PPRC data point the way to a solution. It is distressing to find that the voluntary assignment rate (i.e., excluding Medicaid patients for whom assignment is required) for ambulatory care is only 63 percent for patients below the poverty level. Even if the current level is higher, it is less than 100 percent, meaning that some of the poorest elderly patients still face balance bills. It is also distressing that the assignment rate for those in the range of 150–199 percent of the poverty level—still a low income level—is no different from the rate for patients at 300 percent or more of the poverty level.

The College believes that low income Medicare patients should not face balance bills. Therefore, as part of a reformed payment system, we support a federal assignment policy that is tied to income. While we do not have a specific recommendation on the income level which should be protected, we do not think the poverty level is sufficiently high. That level is only $5447 for a single elderly person and $6872 for a couple (1987 figures). A cut-off in the range of twice the poverty level would provide the protection of mandatory assignment for 35 percent of the Medicare population. A threshold of three times the poverty level would protect 54 percent of the elderly.

We suggest the Committee look to the experience of Rhode Island, Vermont and Connecticut in implementing income-related assignment. policies, and also to the procedures that are established for setting the income-related supplemental premiums for the Medicare catastrophic coverage program. The fears of a stigma associated with an income-related policy can be minimized through the use of an encoded card; it is far easier for a patient to present this card to a receptionist or billing clerk than to have to make an assignment request to the physician or fill out a form.

Finally, tied to a revised policy on assignment and balance billing, another alternative that would provide additional protection for all beneficiaries would be to establish a highly simplified maximum charge. We endorse the PPRC recommendation that this be a fixed percentage above the fee schedule, and not vary by physician as does the current MAAC. This would bring a level of equality or balance to the system so that those above the income thresholds for assignment would not be paying disproportionately higher out-of-pocket expenses than low income patients. It would protect those relatively few patients shown in the PPRC analysis to be caught at the high end of actual charges and percentage of balance bill. Finally, a maximum charge may be particularly necessary for those services which receive the largest reductions under the RBRVS. We would reiterate that such a limit in a reformed system must be far more rational and less cumbersome than the current MAAC.

Coding for Evaluation and Management Services

Research on the RBRVS has made it clear that the current procedural coding system is inadequate for describing evaluation and management services. While codes for technical procedures describe what physicians do, existing codes for evaluation and management services largely describe where it is done and to whom. Visits, for example, are described by type of patient (e.g., new or established), location of service, and sequence of the care (e.g., initial or follow-up). Levels of service (e.g., brief, intermediate, comprehensive) attempt to capture the duration and intensity of the service.

The problem is that these codes do not consistently describe or capture the same activities in the same way; the distinctions are not well defined, nor intuitively obvious. The result, found by the Harvard researchers and the PPRC, is that physicians in different specialties or even within a specialty use the same code to describe and bill for very different services.

Dr. Hsiao and his colleagues found that physicians' time is closely correlated with the work involved in evaluation and management services. On this basis, the PPRC has recommended that time be incorporated into the coding system, as a proxy for measures of content and intensity of service. We believe this proposal is worthy of further examination, but we would be concerned that time as the sole measure may be prone to misuse or abuse, and less readily verifiable than other indicators. The use of time alone also raises questions about whether inefficient providers of services would be unfairly rewarded at the expense of efficient, highly experienced physicians.

We suggest that serious consideration be given to improvements in coding that rely on descriptions of the content of visits. Instead of describing visits as single services, description of the components of the visit would better capture the variety and complexity of visits. For example, case history, physical exam, evaluation services, preventive care, patient counseling, case management services, and literature review. are potential elements of any. single visit and vary as to their presence and intensity from one patient encounter to another. They are also readily understood by practicing physicians, thereby potentially heightening the consistency of coding.

Another important element that may help to distinguish the intensity of caring for one patient versus another is the age of the patient. It is well understood that our oldest patients, particularly the frail elderly, require more time to care for, and may be more stressful, even when other components of the visit may be similar.

The PPRC has undertaken an important study relevant to these questions. The PPRC will be asking physicians to keep records of their discrete activities in a log diary. This work should yield a fully detailed description of the work involved in the bundled complex of evaluation and management services. It holds the promise of forming the basis of a set of content codes that have enough specificity so that each particular service is coded in one, and only one, way.

Content-based codes become particularly important if, as suggested by the PPRC, specialty differentials are eliminated in a new fee schedule. Specialty differentials have been used to capture differences in the value of physician services that reflect the physician's specialty training and experience. With an inadequate coding system relying on a few categories of visits and consultations, the specialty differential has been an important means of recognizing the training necessary to treat multiple and complex diseases involving many organ systems. To the extent that the complexity and intensity of the services rendered by these physicians can be described by a new, content-based coding system, the need for specialty. differentials is reduced.

Budget Neutrality

The College believes that, given the need to reduce the federal deficit, it may be necessary for Congress to consider implementation of the RBRVS under conditions that are not budget neutral. The issue of budget neutrality appears to cause confusion. Many people hear this term and think it means no increase or decrease. As the Committee knows, budget neutrality means the full projected increase that would occur absent any change in law. For Medicare Part B, this is likely to be a double digit increase.

We think the RBRVS makes sense under any budget scenario, is essential to achieving payment reform, and that budget concerns should not derail us from implementation as soon as feasible. It is the right thing to do regardless of the spending total. While we would prefer a conversion factor based on budget neutrality, we are not willing to lose long-term reform based on the RBRVS in a dispute over short-term spending levels.

Phase-In

In testimony to the PPRC, we opposed proposals for a phased implementation of the RBRVS. We particularly opposed a transition along the lines of the DRG model, in which a percentage of the CPR rate would be combined with a percentage of the RBRVS rate, and then shifted annually. That kind of transition would be enormously complicated, in an environment of tens of thousands of physicians' offices, with widely different billing capabilities.

The PPRC has recommended that, after passage of legislation to implement an RBRVS-based fee schedule, there be a two-year period in which the current CPR rates are adjusted in the direction of the RBRVS. This would be an adjustment similar to that accomplished in the 1987 Reconciliation Act, except that the RBRVS amounts would be used to calculate the percentage of the shift in each of the two years. Recognizing the need for the fee schedule to be as complete and accurate as possible, the College believes that such a transition would be relatively simple to implement, and would ease the shift to the fee schedule. Therefore, we support the PPRC recommendation, as long as it is tied to passage of legislation to fully implement an RBRVS-based fee schedule by a date certain.

Along similar lines, we would like to take the opportunity to comment briefly on the President's Medicare budget proposals for FY 1990. In 1987, during Congressional consideration of Part B spending proposals, the College opposed across-the-board freezes or reductions, but supported proposals that would move in the direction of appropriate prices for all services—by cutting payments for services that were overvalued and increasing payments for those undervalued. Congress adopted this approach in the 1987 Reconciliation Act, reducing payments for specified overpriced procedures and setting a higher payment update for primary services than for nonprimary services. We were pleased when the President's budget request for FY 1990 recognized the need to continue to correct the imbalance between primary and nonprimary services. Enactment of these proposals would be consistent with the direction of reform under an RBRVS system and with the transition recommendations of the PPRC.

Controlling Volume: Expenditure Targets

Recently, when we have seen editorial or other comment on the need to control Part B costs, they are frequently prefaced with a note that Part A spending has been restrained.

It is worth re-calling the Part A solution when we think about the expenditure target proposed by the PPRC. The DRG system for hospitals has a simple, direct and straightforward incentive: Beat the fixed price per case, and you pocket the difference; exceed the fixed price, and you eat the costs. This incentive works not on a national level, not even on a regional or state level, but within a single hospital. The challenge is clear, the rewards and punishments are real and immediate, and the tools are within the control of hospital leaders.

Contrast this with the proposed expenditure target. The actions of an individual physician can have no visible impact on achievement of the target. Any positive actions one individual takes may be negated by those of another person. The reward or punishment is vague and uncertain.

A second flaw in the proposed expenditure target is that the notion of meeting some arbitrary target says nothing about ensuring the appropriate level of care. The cap may be set too high, and allow a large amount of inappropriate care that might be eliminated through other mechanisms. Or the target may be too low, and jeopardize the provision of medical care for patients who need it. It is likely that the target would influence the practice behavior of those physicians who are already cost-conscious, while it is ignored by those for whom it is most intended. An artificial target avoids the central questions of how much, and what kind of, care this society is willing to provide.

Third, the concept of an expenditure target would appear to run philosophically and practically counter to the type of thoughtful, targeted approach in which Congress has shown increasing interest. It would appear to move us away from thinking in terms of appropriate price for appropriate services, and towards broad brush approaches of caps and freezes that do not differentiate the good from the wasteful.

Finally, the proposal assumes that the sole contributor to increases in volume is the physician. We would argue that patient demand is an important element, and that patients have to be brought into any workable solution to the question of utilization. Increasingly accepted precepts of patient autonomy challenge the old paternalism of the physician as sole decision-maker, and therefore, challenge the idea that the physician must be the locus of all utilization control strategies. Given the grey zones that exist in our knowledge base with regard to the effectiveness and appropriateness of various medical and surgical interventions, and the choices that frequently must be made without any guarantee of a particular outcome, the highly personal preferences of the individual patient become critical decision factors.

While physicians still direct the use of most services, with the explosion of medical knowledge it is clear that utilization is also affected by patient expectations of levels and types of services (as well as by other influences such as insurance payment policies). This patient impact on utilization can only grow—and should grow—as patients become more knowledgeable about health matters. If we were to adopt new criteria of appropriate care without bringing patients into that process, they rightly would react with concern at being left out of crucial decisions.

We are beginning to know more about how to bring the patient into the decision-making process. Dr. John Wennberg notes that developments in media "provide revolutionary new ways for synthesizing, conveying, and individualizing information that can support a luxurious and active cross-communication between the patient and the physician" (Health Affairs, Spring 1988). This kind of interaction will dramatically enhance the role of the patient in medical decisions and take us further down the road of patient as enfranchised consumer.

Controlling Volume: Practice Guidelines

We have suggested as an alternative to expenditure targets the use of practice guidelines in Medicare payment determinations. The College, which has been developing practice guidelines since the 1970's, before other medical specialties, first brought to the attention of the PPRC the potential role of guidelines in controlling the volume of services. We are pleased that the Commission has continued to recognize that potential. However, we believe the potential goes beyond the educational role discussed by the PPRC to a role in controlling inappropriate utilization of services that would have more immediate impact on Medicare spending than the proposed expenditure target.

The challenge in this area is not so much in creating good guidelines. We know how to do it, and more and more specialty societies are undertaking this responsibility. The problem is that we have only limited experience in the task of getting physicians to use the guidelines, that is, to change behavior from accustomed ways of practicing. There is some evidence that a central element must be education and follow-up, including peer pressure, that is brought to bear on a local level, either within a single hospital or in a community.

At this level, it appears that guidelines can have a significant impact on utilization. For example, the vigorous application of guidelines for respiratory therapy in a Boston hospital resulted in marked reductions in utilization, charges, length of hospital stay, and pulmonary complications, with no increase in morbidity or mortality. A similar effort at the UCLA Medical Center resulted in substantial reductions in the routine use of four labor-intensive and costly laboratory tests.

Until we know better how to change behavior, and can put into place these local mechanisms, a fiscal incentive will be necessary if we are to have significant impact on Medicare expenditures nationwide. We suggest that a proper role for government is to use physician-developed guidelines in payment determinations. We believe there is enough agreement in certain clinical areas to develop guidelines for practice that are backed by strong utilization review and payment denial where appropriate.

Neither Medicare nor any other payer should reimburse physicians for practices which the scientific evidence indicates are inappropriate in the particular case. These guidelines cannot be automatic screens, but should be used to highlight cases for review. The burden should be on the physician to show that the service was medically appropriate and payment is warranted.

We can choose several services and procedures now, and add new ones each year, for which research conducted under the College's Clinical Efficacy Assessment Project, or under the RAND studies, or by others indicates a high degree of inappropriate practice. We can publish and disseminate the guidelines, create the utilization review screens, and produce results quickly.

This is real to the physician. It is controllable. If the physician performs an inappropriate service, he or she does nob get paid.

In proposing the expenditure target, the PPRC says the purpose is to elicit cooperative behavior among physicians in deciding on appropriate practices. If this is the purpose, why use that very remote mechanism? Why not simply start to identify those areas where research has been done, or is underway, and adopt professionally-developed guidelines as Medicare policy—with the fiscal incentive of utilization review to back them up?

Conclusion

Mr. Chairman, you have the opportunity to enact legislation that will have profound impact on the Medicare program and the health delivery system generally. You have the expert advice of the PPRC to call upon as you formulate legislation. The American College of Physicians stands ready to assist in this task as well. We look forward to working with you to enact rational and equitable Medicare reform whose core is the RBRVS-based fee schedule.

Thank you for this opportunity to testify.

RESPONSES TO QUESTIONS SUBMITTED BY SENATOR PACKWOOD

Question. Your association supports the RBRVS but opposes expenditure targets. You support development of practice guidelines to help solve volume concerns and unnecessary utilization, but savings from this strategy are in the distant future.

Given the need to find $2.7 billion in Medicare reductions *this* year, what proposals do you recommend Congress consider which would provide immediate savings and move us toward an RBRVS-like system?

Answer. In the past, when considering proposed savings in Medicare Part B, we have opposed proposals for across-the-board reductions or freezes in payment updates. We have argued that this approach simply aggravates existing disparities among services and geographic areas. Rather, we have supported selective reductions that would be consistent with the goals of long-term physician payment reform. We testified in 1987 in favor of reducing payments for overpriced procedures, and using a part of the savings to increase payments for underpriced, primary care services and for services in underserved areas. This was the approach adopted by Congress in the Omnibus Budget Reconciliation Act of 1987. It is consistent with the principles of the RBRVS-based fee schedule proposed by the Physician Payment Commission.

We were pleased when the President also adopted this approach in proposing Medicare savings for FY 1990. Very much along the lines of OBRA '87, the President's budget proposes further reductions in overpriced procedures, reductions in payments to several highly remunerated specialties, and a freeze in the payment update (MEI) for non-primary care services. These proposals would yield Medicare Part B savings in excess of $600 million. The College believes that these proposals would meet your stated need to provide immediate savings and move us toward an RBRVS-like system.

We would argue respectfully with the assumption in your question that savings from practice guidelines are in the distant future. We cited two studies in our testimony which showed that vigorous application of practice guidelines in two medical centers led to significant spending reductions. While certainly we have to proceed cautiously to implement this approach on a national level, we believe there are several areas in which there is an emerging consensus on appropriate levels of practice.

The Congress could direct the Physician Payment Review Commission to work with medical specialty organizations and recommend procedures to the Secretary for which physician-developed practice guidelines can be used as the basis for strengthened utilization review. These guidelines would have to be translated into payment screening rules for uniform implementation by all carriers in payment determinations. We believe that such a strategy could begin to show savings in a year to two years.

Question. Your organization opposes a separate fee schedule for surgery, as proposed by the American College of Surgeons (ACS). Why?

Answer. A separate fee schedule for surgery violates the central concept of the Relative Value Scale, which is to array all physicians' work on a common scale and relate the resources consumed. Medicine is a continuum of services, and there is nothing that is unique to surgery that argues in favor of separating it out. There is little conceptual difference, for example, between a surgical procedure and an invasive gastrointestinal or cardiological procedure. Congress has recognized previously the necessity of including all physicians in an RBRVS-based fee schedule: the same provision in OBRA '87 that mandated separate fee schedules for radiology and pathology also mandated that these services be included in the RBRVS system when it is implemented. We would be happy to provide additional information should other questions arise on these or related issues.

PREPARED STATEMENT OF SENATOR GEORGE J. MITCHELL

I commend Senator Rockefeller for holding this hearing today to hear the important results of the study conducted by Dr. Hsiao and the recommendations of the Physician Payment review Commission for reform of the physician payment system under Medicare.

As a Senator representing a rural state I have long been aware of the inequity in the system of physician reimbursement under Medicare. This inequity in payment significantly contributes to the serious shortage of primary care physicians in rural areas of Maine and other states.

I commend Dr. Hsiao and his research team at Harvard for the development of the Resource-Based Relative Value Scale. While there has been some criticism of the study, some valid and some invalid, Dr. Hsiao's work has provided us with valuable information which will allow the Congress to begin serious work to reform the current physician payment system.

Dr. Hsiao has been open to constructive dialogue with the Congress and the medical community as he has worked in good faith to accomplish a difficult task.

I am pleased with the recommendations made by the Physician Payment Review Commission. The Commission has not only made important statements regarding the current inequity between primary care and surgical procedures, but has also addressed the significant issue of geographic inequity in physician payment.

The implementation of these recommendations can have a critical impact on access to quality health care for Medicare beneficiaries living in rural underserved areas.

I am also pleased that the Commission has addressed the very difficult issue of utilization control. The rapidly escalating costs of physician services under Part B are caused in large part by the increase in utilization of services. We must address this issue in tandem with the question of equity of reimbursement by procedure.

As you may know, I have been working on outcomes Research legislation for two years. During the 100th Congress I introduced legislation, which became law, to increase the authorization for outcomes research. I am currently working on a second generation bill which takes the next step in the development of medical outcomes research. I am pleased that a number of my colleagues on this committee are working with me on this legislation and strongly support the recommendations of the Commission with regard to effectiveness research.

I look forward to working with my colleagues in Congress and with the medical community to develop a fair and equitable system for physician reimbursement under Medicare. The work accomplished by Dr. Hsiao and the Physician Payment Review Commission is an important first step.

PREPARED STATEMENT OF ALAN R. NELSON

Mr. Chairman and Members of the Subcommittee: My name is Alan Nelson, MD. I am a physician in the practice of internal medicine and endocrinology from Salt Lake City and I am the President Elect of the American Medical Association. With me today is Janet Horan, from AMA's Division of Legislative Activities. The AMA appreciates this opportunity to participate in the Committee's hearing on physician payment reforms under Medicare.

Mr. Chairman, the press release announcing this hearing cites the need to begin the dialogue on "how best we can proceed to reform physician payment." Your interest in this issue is commendable and we appreciate your recognition of the fact that the status quo of how Medicare sets payment levels for physician services is fraught with problems and the time for reform is imminent. The AMA is on the leading edge of activity to analyze physician payment methodologies, and our involvement as a subcontractor in the Harvard University School of Public Health's benchmark work in developing the Resource Based Relative Value Schedule (RBRVS) is an example of our past and continued commitment to the goal of a rational and fair system of payment for necessary medical care.

In discussing physician payment reform, the recommendations of the Physician Payment Review Commission (PPRC) also must be addressed. While the AMA supports many of the PPRC's recommendations and we certainly believe that the recommendations merit close review, we strongly advise against endorsing all of the PPRC recommendations. In your analysis of the PPRC recommendations, we urge you to consider fully our views and activities in the following four major areas: fee schedule issues; volume control through expenditure targets; quality and outcome assessment and mandated assignment.

As a prelude to our more detailed analysis on these important matters, I will clearly state our position:

- *Indemnity Payment Schedule*—The AMA strongly supports the development of an indemnity payment schedule for Medicare, using a resource based relative value schedule (RBRVS).
- Expenditure Targets—No matter how this proposal is couched, the bottom line is that it is nothing more than a system of implicit societal rationing of health care to elderly and disabled Americans. The AMA vigorously opposes the concept of expenditure targets.
- *Quality and Outcome Assessment*—The AMA is taking a lead role in the development of medical practice parameters. We support the Commission's recommendation for increased funding for research into the quality of medical care and outcomes assessment.
- *Medicare Assignment*—Given the promise of an indemnity payment schedule to exert stronger market controls on balance billing, and especially in light of the prevalence of claim-by-claim assignment, the AMA continues to oppose proposals to mandate assignment under Medicare to all enrollees.

FEE SCHEDULE ISSUES

There is little dispute that the Medicare methodology for setting physician payment and reimbursement levels is overly complex and often creates inequitable results. The fact that current physician reimbursement and payment levels are based on 1971 actual charges as their starting point and have been subjected over the years to a myriad of payment and fee controls illustrates why the system is fraught with inequities.

The AMA strongly supports a rational review of physician reimbursement, as has been conducted recently through the Harvard University School of Public Health which published its resource-based relative value scale (RBRVS). In our view, an indemnity payment system utilizing an RBRVS has the best potential for setting future physician reimbursement directions. The AMA believes that such a payment system could ameliorate many of the uncertainties inherent in current Medicare payments and ameliorate inequities. It also would provide patients with a greater understanding of the financial obligations for each service. The RBRVS study now is being analyzed by the Health Care Financing Administration, the Physician Payment Review Commission, the AMA and others. (Our analysis of this activity, unanimously adopted by our House of Delegates in December 1988, is attached.) [1]

At this point, we believe that the current Harvard study and data, *when sufficiently expanded, corrected, and refined,* would provide an acceptable basis for a Medicare indemnity payment system. The AMA has identified seven specific areas of the Harvard study that need additional work prior to its use in Medicare payment determinations:

- Restudy of specialties whose RBRVS data have significant, documented technical deficiencies;

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[1] Retained in the committee files.

- Fundamental improvement of the measurement of relative practice costs and specialty training costs;
- Expansion of the RBRVS to more specialties and services;
- Development of an extrapolation method for visits;
- Revision, refinement, and expansion of pre- and post-service work measurement;
- Expansion and validation of the current extrapolation method; and
- Development of relative value estimates for global surgical services as standard definitions are developed and accepted.

Much of the work necessary to complete and improve the RBRVS is underway in the study's second phase. As a study subcontractor, the AMA is participating actively with Harvard and a number of specialty societies in the process of expansion and refinement needed to produce a technically adequate RBRVS.

EXPENDITURE TARGETS

The Commission's recommendation calling for Medicare expenditure targets constitutes a radical departure from our nation's commitment in creating the Medicare program to provide the elderly with all necessary medical and other acute health care. It will replace that commitment with an implicit system of economic incentives to withhold services to meet the expenditure target. In effect, it calls upon physicians to make the rationing decisions for society on a case-by-case, encounter-by-encounter basis. The PPRC recommendation may appear to be a painless way to hold the line on program expenditures, but the bottom line of a decision to impose expenditure targets is the creation of an implicit system to ration health care. A national target, tied arbitrarily to a formula that depends heavily upon "a decision concerning the appropriate rate of increase in volume of services per enrollee" rather than actual health care needs, provides the starkest possible proof of this point.

In addition to our view that rationing is not an acceptable direction to reduce Medicare expenditures, the American people do not want rationing of health care for the elderly and disabled. *Public opinion surveys consistently find that the American people want to cover the health care needs of these populations:*

- In response to a 1986 poll conducted for NBC News and the Wall Street Journal, when asked: "To help reduce the federal budget deficit, would you favor reduced benefits for Medicare or not? . . . 86% answered that they opposed reduced Medicare spending.
- In response to a 1987 poll conducted for ABC News/Washington Post, when asked: "Should spending for (the Medicare program which helps reduce health care costs for the elderly) be increased, decreased or left about the same?". . . only 3% called for decreased spending, 22% called for spending to stay the same, and 74% called for increased spending.
- In response to a 1988 poll conducted for NBC News/Wall Street Journal, when asked: "Do you want to see the federal government spend more or less money . . . to provide health care for the elderly?". . . only 5% called for less spending, and 83% called for more spending to meet the health care needs of the elderly.

EXPERIENCE WITH EXPENDITURE TARGETS

Establishing a nationwide or regional system of expenditure targets eventually would devolve into a system that would mirror many of the same problems evidenced in those Canadian provinces (British Columbia, Alberta and Quebec) that limit total expenditures for medical and health services. With their experience as a model as to what could happen in our country, there is mounting evidence that limiting program benefits through expenditure targets will result in medically unacceptable results.

As recently reported in the Canadian press, their health system is starting to deteriorate and rationing is now being openly discussed. According to the Canadian weekly newsmagazine Maclean's (February 13, 1989) patients have died after long waits for needed surgery and elderly patients in Montreal hospitals are being kept in diapers because nurses do not have time to help them go to a bathroom. Other examples from these provinces that maintain an expenditure target system present a telling story:

- The wait in Vancouver for psychiatric, neurosurgical or routine orthopedic consultation is 1–3 months, 6–9 months for cataract extraction, 2–4 years for corneal transplantation, and 6–18 months for admission to a long term placement bed.
- Many waiting lists in the province of Quebec for angiograms are six months long.

- The wait in the province of Quebec for coronary artery bypass surgery is 8–9 months.
- Montreal and Vancouver emergency departments often have no capacity to handle new patients.
- In all of Canada, there are only 11 hospitals that are capable of performing open heart surgery (793 in the U.S.), 14 hospitals capable of performing organ transplants (319 in the U.S.), and only 12 hospitals have magnetic resonance imaging (MRI) equipment (there are no MRI facilities outside of hospitals in Canada). [Canadian figures are from 1988 and U.S. figures are from 1987.]

Based on this directly relevant Canadian experience, we do not believe that Congress should experiment on our elderly population with this type of proposal. Such a system is unprecedented in the United States and holds very real risks for our elderly and disabled patients. In the PPRC's testimony before the Subcommittee, they recommended that target rates of increase for the first few years of using such targets "not depart substantially from baseline rates of increase." We applaud this prudent recommendation by the Commission, and we believe that it only proves our point regarding the substantial potential risks that expenditure targets pose for Medicare beneficiaries. We urge you to reject this approach.

GROWTH IN PART B SERVICES AND EXPENDITURES

We also believe that concerns about the continued growth in part B are overstated. Insufficient consideration has been given to some of the very real factors that have led to this increase—including the shift of services from inside hospitals to hospital outpatient departments. (see the attached chart, Appendix I, which demonstrates where the greatest part of Part B growth has occurred) stimulated by both the hospital prospective payment system (PPS) and the continued evolution of technology that has allowed many more and highly complex procedures to be done safely on an outpatient rather than an inpatient basis.

Recent policy debates regarding the volume and appropriateness of care provided to Medicare beneficiaries have increasingly reflected a perception that there is a broad "volume problem," and suspect physician behavior often is alluded to as a primary cause of this problem. As a result of this perception, there has been growing interest in complex regulatory policies to achieve budget savings through controlling volume growth and reducing levels of unnecessary care. Although the AMA fully supports the elimination of unnecessary care—and we only wish that all of the needed savings could be generated by such a simple solution—the truth of the matter is that physicians are not causing vast unnecessary program expenditures. The major factors that have contributed to program growth include:

- Improved techniques and technology that make consumption of medical care easier, safer, and more accessible;
- Patients being provided more and better information about the benefits of medical care, especially preventive services and procedures; and
- the cost-sharing provisions of Part B have eroded, resulting in increased demand for medical care.

An analysis of Medicare data by Northwestern National Life Insurance in Minneapolis revealed that "new seniors" (those that are joining the group of age 65 or older) use more health care services than their counterparts 10 years ago. Specifically the analysis found that those individuals becoming eligible for Medicare in 1988 were using health care at an 11% higher rate than the past decade. This rate includes an adjustment for inflation. (A detailed analysis on this issue is attached to this statement as Appendix I and II.)

QUALITY AND OUTCOME ASSESSMENT

Rather than imposing restrictive expenditure targets, efforts to improve quality and outcome assessment to eliminate unnecessary or inappropriate services should be accelerated. This goal can best be achieved through funding of research into quality assessment so that clinically sound guidance can be provided to physicians to integrate into their practices. We agree with the Commission in its recommendation for increased funding in this area. We believe that the focus of such research should be within the office of the HHS Assistant Secretary for Health. We also support improved utilization review. Such research and information transfer will benefit patients and Medicare itself and enable the program to continue to meet its commitment to the elderly.

Appropriateness of care is directly related to the issue of volume. We believe that review of care, to be successful, must be based on physician-developed appropriateness criteria and on coverage decisions that preserve patient access to quality medical care. When utilization management programs are *not* run properly, the provision of *quality* health care to program beneficiaries is compromised. Too often, reviewers with little or no clinical training are given authority to deny claims as "not medically necessary." As we have seen, some carriers actually deny claims on the basis of "screen failure" alone without necessary claims development.

One potential and we think workable solution to help assure the provision of high quality care is the development of practice parameters. The AMA strongly supports the development of clinically relevant parameters that are designed to assure that patients receive appropriate medical care. Through our Office of Quality Assurance and Assessment, the AMA is taking the lead role in clinical appropriateness initiatives. The Association has entered into a landmark agreement with the RAND Corporation to develop practice parameters that will have a major impact on the future practice of medicine. (A copy of this agreement is attached as Appendix III.) The AMA is also working with the national medical specialty societies to refine research methodologies and develop dissemination techniques to provide useful and educational information to practicing physicians. Clearly, medicine does not require punitive expenditure targets to act effectively and responsibly to reduce inappropriate care. We expect results from this project beginning in 1989.

MANDATED ASSIGNMENT

The AMA supports the Commission's current decision to not recommend mandated assignment under the Medicare program. As you well know, mandated assignment would require physicians to accept the Medicare I allowed amount as payment in full regardless of the excellence or unique nature of the services provided or the ability of the patient to pay the physician's regular charge for the service.

Medicare already substantially discounts physicians' fees. The gap between Medicare allowed amounts and physicians' regular fees has grown from 10% in 1970 to the current approximate level of 27%. In other words, years of budget cuts and regulation have left Medicare paying only 73% of physicians' regular fees.

In any discussion of mandatory assignment, it must be realized that the total a physician may bill a patient between the allowed amount and the maximum allowable actual charge represents only a small percentage of the total out-of-pocket expenses a Medicare beneficiary may experience. HCFA estimates average out-of-pocket costs of about $600 in 1987 per aged beneficiary for Part B services, balance billing amounts accounted for about only 18%; while co-insurance amounts accounted for approximately 32%, deductibles accounted for approximately 12%, and premiums accounted for approximately 38% of patient financial liability. (See attached chart, Appendix IV.)

It is also important to note that physician balance billing and other beneficiary expense responsibilities do not represent a financial barrier to needed care. The data from the PPRC's beneficiary survey report that only 6.4% of respondents did not seek care during the previous year because of the cost, with only 3.1% putting off treatment for a serious condition. Only 0.2% reported being actually denied care for financial reasons (including deductible, co-insurance and balance billing). Although any delay in seeking treatment due to financial considerations is worrisome, these numbers do not suggest that balance bills exert a negative impact on access.

This record clearly demonstrates that physicians do care about their patients' economic circumstances and accept assignment a vast majority of the time. Physician acceptance of assignment has continued to increase to all-time record highs. The fact that close to 80% of charges for physician services are assigned demonstrates that physicians are responsive to their patients' situations. The AMA encourages physicians to take their patients' economic status into account and data show that they do. An Urban Institute study summarized evidence that physicians are more likely to assign claims in low-income areas. The Physician Payment Review Commission's physician survey revealed that patients over age 75 were more likely to have claims assigned, and that claims are more likely to be assigned if the patient lacked supplementary insurance. Another PPRC analysis found that voluntary assignment rates were higher for poor patients than for better-off ones. Consider the following points from the PPRC surveys:

- For individuals with a regular source of care, the PPRC beneficiary survey reported that the voluntary assignment rate (excluding Medicaid) from the patient's regular physician was 56%, and 68% on the last visit with a specialist. The physician survey found that of non-participating physicians, 85% routinely accepted assignment for some of their patients, regardless of the service provided, and that 95% of these physicians consider the patients financial status in this decision.
- When beneficiaries were asked whether they were actually balance billed on their most recent bill, only 17% indicated that they had been, with those over age

85 and those below 200% of the poverty level least likely to have received such a bill.

- A PPRC analysis of 1987 data from eight states found that 3% patients had annual balance bills exceeding $500, that 52% had no balance billing liability and 30% had balance bills of $50 or less. Even among those patients with more than $5,000 in annual Medicare allowed charges, the majority had $50 or less in balance bills.

Policy approaches that restrict or eliminate physicians' ability to establish their fees are not warranted. When one studies the distribution of balance bills and the actual amount of individual bills, as the PPRC has, it becomes clear that there simply is not a large enough number of persons who are experiencing substantial financial problems from balance bills to justify mandating assignment or imposing stringent charge restrictions for all Medicare beneficiaries.

With a Medicare fee schedule, the problems of mandatory assignment would be compounded because no fee schedule can adequately reflect differences in practice costs, patient severity, quality, amenities and other factors. Without the ability to balance bill, there will be no recognition of experience or other special abilities. The remuneration for a physician on his or her first day of practice for a service will be the same as for a highly skilled practitioner with decades of practice and experience.

For many of the same reasons, we oppose the Commission's recommendation to control physicians fees through what would amount to a new set of Maximum Actual Allowable Charges. Controls on physician fees should not be imposed while the rest of the economy is unregulated. Such fee controls encourage utilization by keeping the price of medical services low to consumers and do not reflect increases in the costs of services that physicians must pay in the uncontrolled market. They will distort the payment system in a manner similar to mandatory assignment. We believe that the MAAC program should really be allowed to terminate as Congress intended.

It also must be realized that limits on balance bills will pose a financial risk to the Medicare program. Studies on the effects of cost-sharing by the RAND Corporation and the Congressional Budget Office indicate that elimination of balance billing could greatly increase Medicare expenditures. (Price controls also carry other substantial risks, as pointed out by eleven prominent economists in the attached Appendix V.)

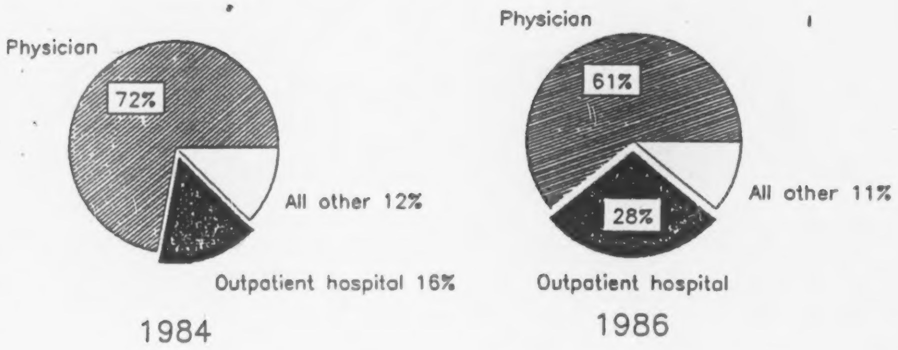
Finally, let me expand on the AMA's efforts in encouraging physicians to consider their patients economic status in the assignment decision. There are currently 34 state medical society voluntary assignment programs either underway or in development. Additionally, there are numerous county programs in effect, many in areas without state programs.

CONCLUSION

Mr. Chairman, health care in this nation is approaching a crossroads and the choice of which road we pursue will fashion our health care system for the American people into the 21st century. We urge caution so that the decisions you make now do not take us down the wrong road—a road where Americans have to line up and wait for essential care as seen in the expenditure target provinces of Canada, or a road that denies services to citizens based on age as seen in Great Britain.

The choices you face are important ones, and we urge you to follow the directions that will assure our continued ability to care for our nation's elderly and disabled.

Medicare Part B Spending By Type of Service



APPENDIX II.—MEDICAL PART B EXPENDITURES, ANALYSIS AND GROWTH

INTRODUCTION

Part B of Medicare covers physician services and a variety of other health care services, such as laboratory and outpatient hospital services. Disbursements for the Part B program have been the fastest growing nondefense expenditure item in the federal budget in this decade, having increased an average 16.3 percent annually between 1980 and 1987.

Even after inflation in medical care prices has been taken into account, total real disbursements increased at a 7.4 percent average annual rate. Growth in the enrolled Medicare population of 1.9 percent per year accounts for only a small amount of the real growth. The "residual" component of the inflation-adjusted growth that is not explained by beneficiary demographics (5.5 percent) is broadly attributed to increases in "volume" of services per eligible beneficiary and to increased "intensity" of services; i.e. more services per visit.

This report concerns that residual component of outlay growth not due to price inflation or enrollee increase, with special emphasis on the underlying factors responsible for the growth.

COMPONENTS OF PART B OUTLAYS

An accounting adjustment gives a truer picture of cost growth in the Part B program. The usual practice of focusing on cost per enrollee overstates the growth in "volume and intensity" when the proportion of enrollees who actually receive services is also growing. Analyzing costs on a per enrollee basis results in confusing the increased number of users as part of the increase in volume per enrollee. According to the General Accounting Office, the number of persons served per 1000 enrollees increased by about 16 percent between 1980 and 1986 (United States General Accounting Office, 1988). This means that growth in real outlays *per service recipient* was 3.0 percent per year.

To better understand the nature of Part B expenditures, it should be kept in mind that:

- physician services are about 60 percent of total Part B allowed charges;
- outpatient hospital department (OPD) services are about 28 percent of total allowed charges; and
- OPD allowed charges grew an average of 30 percent per year compared to 13 percent for physician services from 1980 to 1986.

These figures show that outpatient hospital services are a substantial component of the Part B program and contributed more to expenditure increases than physician services in recent years.[1]

A recently completed study of Medicare claims data for five states for the years 1983 through 1985 reached the following conclusions (West et al. 1988):

- the major sources of growth in OPD services have been expanding use of OPD surgery and growth in the proportion of eligibles receiving services;
- the expanding use of OPD surgery has resulted in increasing the average allowed charge per service across all services, a common measure of "intensity;" and
- aggregate upcoding explains only a small percentage (4%) of the total increase in Part B allowed charges.

These findings suggest that the high rate of Part B expenditure growth is primarily confined to hospital outpatient departments, that patient demand has played a significant role, and that the extent of visit and procedure upcoding is far less than has previously been speculated by some analysts.

CAUSES OF INCREASED VOLUME AND INTENSITY

In the past year, research based on new sources of data has begun to replace speculation with documentation on the causes of Part B volume/intensity growth. Research findings fall into four broad areas:

- patient demand;
- technical innovations in outpatient services;
- third-party reimbursement practices; and
- trends in physician supply.

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[1] Center for Health Policy Research, American Medical Association, Chicago, Illinois, February, 1989

At a recent research conference on Part B volume growth held by the Leonard Davis Institute for Health Economics of the University of Pennsylvania and jointly sponsored by the AMA, there was much agreement among economists that the nature of volume increases evident in this new information is largely a manifestation of increases in patient demand. Demand effects may be broadly separated into two categories: factors that lower price to the patient at the point of service; and non-price factors that increase the amount of services demanded at a given price. Specific research findings include:

- Over the 1980–87 period, legislation raised the Part B deductible only once and increases in premiums were offset to a large extent by patient savings due to the increase in *assignment rates* (United States General Accounting Office, 1988).
- The 40-month *fee freeze* of 1983–1987 allowed inflation to erode the real price of services, as has the subsequent MAAC program which has held fee increases below inflation.
- The *prevalence of medigap insurance,* which typically provides nearly first-dollar coverage, eliminates the constraints on unnecessary use intended to result from Medicare's cost-sharing provisions. As a result, use of Medicare-covered services is higher than it would otherwise be, and most of the costs of the additional services used are paid by Medicare rather than by *medigap* insurers. The effect of medigap coverage for the typical Medicare-not-Medicaid enrollee is to increase use of both physician and hospital services by about 24 percent. Over 80 percent of aged Medicare enrollees had either medigap insurance or Medicaid coverage in April 1984 (Christensen et al., 1987).
- As a group, *the elderly are economically better off* than the younger working-age population. In 1986, the average net worth of households with head of households between 65 and 74 years of age was $249,844, compared to $152,391 for households with head of household between 45 an 64, and $56,563 for households with head between 25 and 44. The greater wealth of elderly households would be expected to contribute to a greater demand for health care services.
- Medicare *patients are becoming more aggressive consumers* of medical care and more knowledgeable about the availability and benefits of new technology and procedures. For example, in the four months following President Reagan's cancer surgery in 1985, an estimated 73,000 additional colonoscopies were performed on Medicare patients (McMenamin, 1988).
- The biggest source of increase in approved charges per enrollee in recent years has come from outpatient surgery. The convenience of the outpatient setting significantly *lowers the time price and the psychic cost* to patients, affecting demand similar to a reduction in money price and resulting in a *substantial net increase* in the numbers of such procedures (West et al., 1988).

Improvements in the provision of medical services has proceeded apace on several fronts and are making the consumption of medical care easier, safer, and more accessible.

- Clinical innovations in outpatient procedures, as for example in cataract surgeries and endoscopies of the digestive system, have resulted in better products and allowing the physician to do more.
- As a result, *outpatient services are in fact increasing the cost of U.S. health care* in the private as well as public sectors; the Blue Cross and Blue Shield Association found that the number of outpatient visits per thousand people covered jumped 26 percent between 1981 and 1987 and the cost per visit rose 88 percent (Raynor, 1989).
- While the number of visits per person has remained relatively stable, *the length of visits and the number and types of services provided has increased;* specific examples are found in cardiology, thoracic surgery, gastroenterology, and ophthalmology. (Mitchell et al., 1988)

The insurance industry has been responsible for contributing to the shift to outpatient care. Most insurance companies reimburse 100 percent for outpatient care and 80 percent for inpatient care. (Blue Cross and Blue Shield, however, continues to reimburse 80 percent for procedures regardless of where they are performed.) It is natural for patients to seek out the lowest-cost care setting.

The increasing physician supply has resulted not only in increased access but a reduction in prices of physician services as evidenced by the increasing numbers of salaried physicians and increasing physician participation in PPOs and acceptance of discounted fee-for-service payment (Falk and Langwell, 1988).

PART A VERSUS PART B

Proposed federal budgets for both Part A and Part B were cut substantially by the successive budget reconciliation bills enacted during the 1980s. The sum of the budget savings estimated by HCFA for ORA, OBRA-81, TEFRA, DEFRA, COBRA, and OBRA-86 is approximately $18.2 billion for Part A and $13.4 billion for Part B (United States General Accounting Office, 1988). This represents a 6.9 percent reduction in cumulative Part A outlays and a 10.9 percent reduction in cumulative Part B outlays. Thus, relative to the respective program sizes, Part B was cut about one and one-half times more than Part A.

Nevertheless, Part A spending growth in the 1980s has been well below its trend in the 1970s; in contrast, Part B growth has been about the same. The hospital industry has clearly been affected by these Part A cuts, especially in rural areas. The cost-saving effects of the budget acts have been offset by increased utilization of Part B services: 40 percent for OPD services and 15 percent for physician and other Part B services.

CONCLUSION

In many ways, the growth in Part B outlays reflects the success of medicine in making available more and better care to the patient, which in turn has led to increased consumption of medical care:

- Improved techniques are making consumption of medical care easier, safer, and more accessible;
- Patients are being provided more and better information about the benefits of medical care, especially preventive services and procedures; and
- More options are being made available to patients, especially outpatient alternatives to inpatient procedures, affording them wider choice among alternative approaches to managing medical problems which they may choose based on personal subjective criteria.

At the same time, erosion of the cost-sharing provisions of Part has also resulted in increased growth in demand:

- Constraining fees by limiting MEI updates, freezing fees, and imposing MAACs has resulted in real growth in allowed charges per service below the rate of inflation;
- Medicare allowed charges are now less than 80 percent of physicians' usual fees; and
- The increasing prevalence of medigap insurance and acceptance of assignment neutralizes cost-sharing requirements.

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APPENDIX III.—THE AMA/RAND CLINICAL APPROPRIATENESS INITIATIVE MEMORANDUM OF AGREEMENT

The American Medical Association and The RAND Corporation have established a cooperative project to improve the health of the American people by developing a process to identify appropriate care and reduce inappropriate care.

This project will:

1. Establish a system to develop appropriateness criteria for selected medical and surgical procedures, diagnoses and conditions.
2. Develop clinically relevant practice guidelines based upon the appropriateness criteria.

3. Disseminate these practice guidelines to assist physicians in clinical Decision-making.

4. Evaluate the effectiveness of the project in improving the appropriateness of medical care.

RAND plans to conduct its activities in collaboration with a consortium of academic medical centers. The AMA plans to conduct its activities in collaboration with the national medical specialty societies, state and local medical societies.

Project Plan

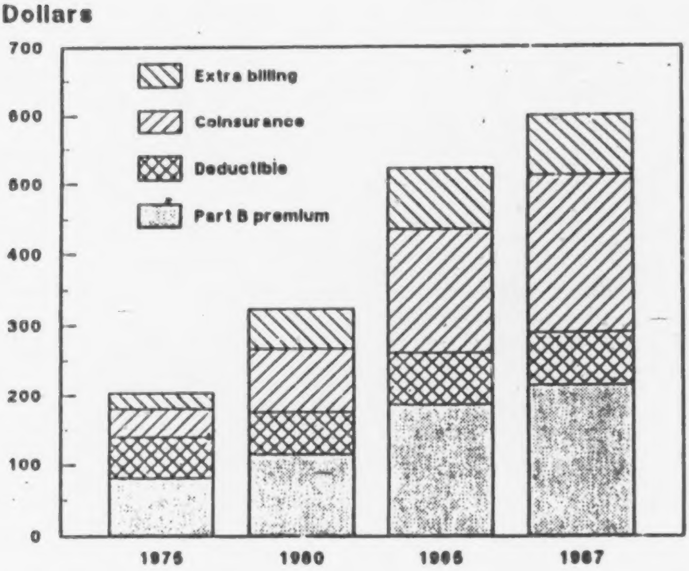
This project will consist of eight major activities:

1. Production of appropriateness criteria for selected medical and surgical procedures, using existing methods.
2. Research to improve the methodology to develop appropriateness criteria for medical and surgical procedures.
3. Research and development regarding diagnosis-based and/or condition-based appropriateness criteria.
4. Production of appropriateness criteria for additional procedures, diagnoses and conditions.
5. Development of practice guidelines based on the appropriateness criteria.
6. Development and testing of methods for dissemination and use of the practice guidelines.
7. Research to evaluate the effectiveness of the project in improving the appropriateness of medical care.
8. Development of a system for maintaining and updating the appropriateness criteria and the practice guidelines.

Institutional Responsibilities

RAND will have responsibility for the research on and development of appropriateness criteria, and the AMA will serve in an advisory capacity on that activity. Tile AMA will have responsibility for the development and dissemination of practice guidelines based on tile appropriateness criteria, and RAND will serve in an advisory capacity on that activity.

AVERAGE ESTIMATED OUT-OF-POCKET COSTS PER AGED ENROLLEE FOR COVERED PART B SERVICES SELECTED YEARS: 1975-1987



SOURCE: HEALTH CARE FINANCING ADMINISTRATION
OFFICE OF THE ACTUARY, DIVISION OF COST ESTIMATES

RESPONSES TO QUESTIONS SUBMITTED BY SENATOR PACKWOOD

Question. I am very concerned about the skyrocketing increases occurring in Part B physician services. Expenditure targets would help slow these tremendous increases. Since you oppose the use of expenditure targets and the successful use of practice guidelines is many years off, what do you suggest as a way of dealing with the increases in Part B services?

Answer. Expenditure Targets would inappropriately force physicians on a case-by-case basis to make unconscionable decisions about withholding necessary services to patients. It punishes the conservative as well as the profligate physician without giving any guidance to either. ETs would only exacerbate the problems of rural and inner-city areas in attracting physicians and worsen the plight of struggling hospitals servicing those areas. Proponents are responding to the need for budget cuts, not the needs of patients, consequently ETs will always be set unrealistically low. ETs create an implicit system of economic incentives to withhold services on an encounter-by-encounter basis.

While the AMA recognizes the demands of the budget deficit, there are already adequate proposals before Congress that will provide the savings necessary for the Medicare Reconciliation budget mark for this year. ETs contribute *nothing* in FY90 savings.

The AMA recognizes the need for longer range alternatives and proposes the following:

A. DEVELOPMENT OF PRACTICE PARAMETERS. Parameters reduce inappropriate, not appropriate care. ETs could reduce both arbitrarily. Practice Parameters do work, as evidenced by the following two examples: (a) Practice Parameters on caesarean sections led to a reduction in caesarean section rates at a Chicago hospital from 17.5% to 11.5%. Nationally, that would lead to savings of approximately $1 billion per year; (b) In 1984, the American College of Cardiology and the American Heart Association published guidelines for permanent cardiac pacemaker implantation. Current estimates indicate a 28% decline in pacemaker implants between 1983 and 1986.

B. PROFESSIONAL LIABILITY REFORM. As much as $2 billion could be saved through reductions in premiums and defensive medicine costs by the enactment of federal incentive legislation to encourage state tort reforms.

C. REDUCTIONS IN NON-PHYSICIAN PART B SERVICES. Hospital Outpatient Department (OPD) costs are the fastest growing component of Part spending, growing at an average of 30% per year from 1980 to 1986. In contrast, physician services grew at a rate of only 13% per year during that same time period. OPD payment grew from 16% of Part B spending in 1984 to 28% in 1986, while physician services decreased from 72% of Part B to 61% in that same time period.

D. ENACTMENT OF LONG TERM MEDICARE REFORM. Rep. Charles Rose (D-NC) has introduced HR 2600, a bill to restructure Medicare on a fiscally sound basis. This bill would enact the recommended reforms supported by the AMA.

Question. Your organization opposes a separate fee schedule for surgery, as proposed by the American College of Surgeons (ACS). Why?

Answer. The AMA supports the general principle that an RBRVS-based payment schedule should include differentials in payment for CPT codes where there are differential resource costs ("total work" and practice and training costs) across specialties. The following criteria should guide the establishment of differentials for specific services:

a. When the resource costs are substantially different across specialties; and

b. When the relevant codes are not sufficiently precise to differentiate among the content or physician work of a service across specialties, and cannot be readily refined to become so.

In addition, as few separate payment categories as possible should be established to minimize system complexity. In general, specialty differentials should be avoided except where absolutely warranted by resource cost data.

Specialty differentials should apply to all CPT-coded services for which a differential exists.

Where specialty differentials exist, criteria for specialty designation should avoid sole dependence on rigid criteria, such as board certification or completion of residency training. Instead, a variety of general national criteria should be utilized, with carriers having sufficient flexibility to respond to local conditions. In addition to board certification or completion of a residency, such criteria could include, but not be limited to:

- Partial completion of a residency plus time in practice;
- Local peer recognition; and

- Carrier analysis of practice patterns.

A provision also should be implemented to protect the patients of physicians who have practiced as specialists for a number of years. (For a more detailed discussion on the specialty differential issue, please see pp. 31-35 of the AMA Board of Trustees' Report AA (I-88) which is attached.)

Specialty specific ETs imply different conversion factors which would lead to a movement away from the resource based methodology to establish value. That result would be counter to the studies encouraged by the Senate Finance Committee over the years.

Question. Do you have data on the number and extent of liability suits of Medicare beneficiaries and how they compare to the rest of the population?

Answer. The AMA does not have any such data.

Question. Doctors often argue that there are important differences among patients, even when they all receive the "same" services. Suppose that a Portland doctor chooses to treat patients who are consistently more difficult than the typical practice—for example, they tend to have mild senility problems. Does the AMA believe the PPRC's resource-based fee schedule could adequately compensate this physician who treats patients requiring more than the "average" time or skill? What, if anything, should be done to compensate such doctors?

Answer. The AMA policy supports the adoption of a fair and equitable Medicare indemnity payment schedule under which physicians would determine their own fees and Medicare would establish its payments for physician services using: (a) an appropriate RVS based on the resource costs of providing physician services; (b) an appropriate monetary conversion factor; and (c) an appropriate set of conversion factor multipliers.

The AMA supports the position that the current Harvard RBRVS study and data, *when sufficiently expanded. corrected. and refined,* would provide an acceptable basis for a Medicare indemnity payment system. The RBRVS would be used to determine the government payment. The ability of the physician to establish and maintain his or her own fee structure, and balance bill on a claim by claim basis would enable individual physicians to bill patients in a manner that would reflect differences such as presented in your question.

Question. I understand that doctors would prefer to have no MAAC-like caps on charges to patients. I am pleased to hear that most—but not all—doctors voluntarily take a patient's ability to pay into account before billing beyond the allowed amount. Let's assume that there is no mandatory assignment for the poor:

1. What measures, if any, would the AMA take to help those patients who are poor, and do get billed more than the allowed amount?

2. Why do some physicians bill the poor for costs beyond Medicare allowed charges now?

Answer. Retention of the ability to balance bill under a new Medicare physician payment system remains a major AMA policy objective. The physicians' current right to decide on a claim-by-claim basis whether or not to accept Medicare assignment has not been abused, as evidenced by the over 80% assignment rate.

Evidence from the PPRC physician survey shows clearly that most physicians base assignment decisions on the patient's financial situation, rather than on other factors or on the specific service or procedure involved. Most responded that their patients volunteer information on their financial status. They also know from the patient's previous history or ask the patient.

(For further discussion on this issue, please see pp. 22-25 of the AMA Board of Trustees' Report AA (I-88).)

The AMA supports state and county medical society-initiated voluntary assignment programs for low-income Medicare beneficiaries. Also, the AMA supports expansion of Medicaid to include all with incomes below the poverty level (with state adjustments). Under current law, all dually eligible beneficiaries are seen by physicians on an assigned basis.

PREPARED STATEMENT OF SENATOR DAVID PRYOR (MARCH 17, 1989)

Mr. Chairman. The Subcommittee is gathered here today to discuss the Physician Payment Review Commission's 1989 report to Congress. Physician payment reform is one of the most difficult issues we have on our agenda in the 101st Congress. This year, PPRC's report will focus on the implementation of a fee schedule for Medicare physician payment.

In recent years, Medicare's Part B program has been the target of criticism aimed at its inflationary and inequitable fee-for-service reimbursement system, and its seeming lack of control over growing expenditures and beneficiary out-of-pocket costs. Needless to say, Part B of the Medicare program is beset with problems. At the Subcommittee's last hearing, we heard about its spiraling costs, which are largely a result of increased outlays for payments for physicians' services. Physicians services accounted for two-thirds of all Part B outlays in fiscal year 1988, for a total of $24 billion. While expenditures for hospitals exceed those for physicians' services under Medicare, their growth rates in recent years are dramatically different—about 6 percent per year from 1984 to 1988 for hospitals compared to 14 percent for physicians' services in that same time period.

Medicare's current fee-for-service reimbursement system for physicians' services, based on the lowest of the customary, prevailing or reasonable (CPR) charge, has been blamed for much of this increase as it provides little incentive for physicians to deliver cost-effective care. Controls on both volume and price must be in place if expenditures are to be kept in check, and CPR provides neither. The original design of CPR was inflationary because physicians' maximum allowable charges for any given year were based, in part, on their charges in the preceding year. As a result, an increase in current charges would increase future charges. Further, a fee-for-service reimbursement system rewards volume—the greater the number of services rendered, the higher the reimbursement, provided the reimbursement is commensurate with the actual cost of delivering the service.

Many other problems exist with the current system. A great deal of variation exists in reimbursement depending on the specialty of the physician delivering the service, the geographic location, the setting where the service is rendered, as well as the type of service. That is, a physician can usually receive a higher reimbursement for a "procedural" or medical service using medical devices and equipment than for a nonprocedural service, such as a routine office visit.

Beneficiaries, too, are feeling the adverse effects of the current system. Unlike hospital care, physicians do not have to accept Medicare-approved charges as payment in full for services rendered to Medicare beneficiaries. Although a majority of Medicare claims are "assigned", and growing numbers of physicians are "participating physicians," balance-billing still represents a significant burden on many beneficiaries, particularly those with low incomes, who may not have medigap insurance to cover balance-billing charges.

The Physician Payment Review Commission appears before us today to provide us with its recommendations for a fee schedule based on the resource-based relative value scale (RBRVS) developed by William C. Hsiao, Ph.D. Dr. Hsiao's RBRVS bases payment for services on the amount of time and effort a physician puts into a service. Many believe that a fee schedule based on the RBRVS would be more a more equitable system, as it would reflect what is perceived as relative overpayment for surgical and diagnostic services and relative underpayment for primary services.

While I applaud the development of a reimbursement system that would pay all physicians equitably, I am concerned that we not permit that issue to blind us to other, equally pressing concerns. The fee schedule by itself does not have a mechanism with which to control the volume of services delivered, which is one of the primary reasons for rapidly increasing Part B expenditures. Beneficiaries' out-of-pocket costs and access to needed, quality services must also be factored into any discussion of changes made to the way Medicare pays physicians. We must work to ensure that everyone—the federal government, the medical community, and beneficiaries—is treated fairly under any new system that we put into place. We have a great challenge before us, with no easy or obvious solutions. I look forward to the testimony of our distinguished witnesses here today to get us started in the right direction.

PREPARED STATEMENT OF SENATOR DAVID PRYOR (APRIL 20, 1989)

Mr. Chairman. Today, the Subcommittee on Medicare and Long-Term Care meets for the second time in little over a month to examine the issue of physician payment reform under the Medicare program. We will hear testimony from various physician groups and the American Association of Retired Persons on how reforms in the way that we pay for physicians' services will affect their members. Today's emphasis will be on the Physician Payment Review Commission's recommendations concerning the resource-based relative value scale approach to physician payment.

I look forward to this discussion, and the many that will undoubtedly follow, with both excitement and trepidation. I am excited because I believe Congress finally has the impetus to consider the need for fundamental changes in our entire health care system, not just in the way we pay for physician services. Senators and Representatives are hearing more and more from their constituents that our current health care system is simply not working right, and that the time has come for us to do something about it. My trepidation, however, comes from the fact that while it may be safe to say that there is a consensus as to the need for reform, there is virtually none as to how we do it.

A desire to achieve consensus on physician payment reform is why we are meeting here today. While I do not expect that we will arrive at a reform policy that will make the Congress, beneficiaries, physicians, and all other interested parties equally happy, I am confident that by working together—as we are doing today—we can develop a plan that will be recognized as necessary and acceptable to most everyone.

As Chairman of the Special Committee on Aging, I am especially concerned about the effects of reform on beneficiaries. Protecting their physical and financial health is paramount to me. I am keenly aware, however, of the need to recognize the wide range of valid interests concerning this issue. We must come up with a fair and equitable payment system. To accomplish that, it is crucial that we listen carefully to all viewpoints.

1 commend Chairman Rockefeller for his thoughtful, considered approach to this complex issue. With his leadership, and the advice of distinguished panels such as the one before us today, we are off to a strong start toward important comprehensive reforms in the way that the federal government pays for physician services.

PREPARED STATEMENT OF SENATOR JOHN D. ROCKEFELLER IV

Good morning ladies and gentleman. This morning, the Subcommittee on Medicare and Long Term Care begins consideration of the questions of whether and how to reform the way Medicare pays physicians. During this and subsequent hearings, we will closely examine and explore idea for improving Medicare's physician reimbursement system.

There doesn't seem to be much disagreement that the physician payment system needs a major overhaul. The current Medicare methodology for physician reimbursement is barely comprehensible. It is confusing not only for senior citizens but for the doctors themselves.

Medicare spending for physician services has increased at an annual rate of 15 percent since 1980. A variety of strategies has been tried to restrain these program costs but, for the most part, these measures have been unsuccessful or inadequate. This subcommittee heard testimony two weeks ago that even without program expansions, Medicare spending for physicians' services is expected to triple over the next tan years.

Unless major changes in the system are made, Congress will be forced year after year to tinker around the edges to achieve "budget" savings without really making any long term difference or achieving any real gains in patient care and services and in the way the system works.

What strikes me as a compelling reason for physician payment reform is the increasing financial burden on Medicare beneficiaries. Senior citizens are paying more and more out-of-pocket for health care. In 1988 the elderly spent just over 18 percent of their limited incomes on health care expenses, up from 12 percent in 1977. Unless we can reverse past trends, Medicare beneficiaries will continue to see their health care bills rise.

Today's hearing is the first in a series of hearings that will be held by this subcommittee on physician payment reform. I am brand-new to the subject and have a lot to learn. Working with Senator Bentsen and his staff, and all of the Finance committee members, I hope to do all I can to ensure that we have a process in which everyone participates and all points of views are heard.

I anticipate a healthy dialogue and a lively debate on the matter of physician payment reform. The Medicare physician payment system has essentially been unchanged since the Medicare program was first enacted. The type of structural changes Dr. Lee and Dr. Hsiao will be testifying about today could have profound implications on the practice of medicine and the health care that our seniors receive.

Although today marks the beginning of Congressional debate, I know that Dr. Lee and Dr. Hsiao have been immersed in this subject for a very long time. I applaud you both for your efforts and dedication. You will be looked to often for expert advice and assistance as we explore Medicare physician payment policies. I am very pleased that this subcommittee has the opportunity to hear first hand your thoughts and ideas on how we might begin the tremendous task before us.

As we know, the Medicare program was created as a major new commitment of the federal government to the nation's senior citizens. In the early years, the Medicare program was viewed skeptically by many in the medical profession. I am pleased that the AMA and many other professional groups are very much involved and active participants in the current debate on improving part of the system. We encourage and welcome the help of the entire physician community throughout this process.

The task before us is huge and complex, and we must proceed with caution and care. If and when changes to the current system are developed, I believe we must be; mindful of several key goals—access, quality of care, acceptability, and fiscal soundness. I am optimistic we all can come up with changes that are rational, well-understood, and widely-supported.

Again, I welcome the witnesses this morning. I look forward to an interesting and educational morning.

PREPARED STATEMENT OF GEORGE W. WEINSTEIN

Mr. Chairman and members of the Committee, I am George W. Weinstein, MD, FACS, a member of the American College of Surgeons' Board of Regents. Accompanying me is Paul A. Ebert, MD, FACS, who is the Director of the College. The College appreciates once again the opportunity to present its view on Medicare physician payment issues.

Mr. Chairman, the College and representatives of the major surgical specialty societies have completed a thorough reexamination and assessment of many of the payment policy concerns that this Committee will be addressing. We wish to take this opportunity to put before you a comprehensive set of new proposals for dealing with a number of major payment reform questions, including the problem of expenditure control. The elements of our plan are focused principally on the quality, volume, and cost of surgical services provided to Medicare patients, although we believe that features of the plan could have broader application. Equally important, we believe that new Medicare beneficiary protections should be added to the program during implementation of this plan.

In brief, Mr. Chairman, this plan consists of the following complementary elements:

1. A plan to moderate the growth in Medicare outlays for surgical services by addressing the issue of volume and to make those expenditures more predictable for beneficiaries and the government;
2. A set of proposals for improving the financial protection of Medicare patients through fundamental changes in the assignment program;
3. The development of a new, blended Medicare fee schedule for surgical services that reflects both improved measurements of supply-side, or resource cost inputs, with important demand-side considerations, including the efficacy and relative benefits of treatments as seen by both physicians and patients; and
4. An explicit timetable for phased implementation of the proposed changes.

Mr. Chairman, at the heart of our new comprehensive plan is a public commitment from the American College of Surgeons, the surgical specialty societies, and their more than 85,000 members, to work directly with the Congress—and we hope with the beneficiary community—to reach an agreement on a broad range of physician payment goals that can be implemented in an orderly manner.

As you may be aware, the College testified recently before the other body. On that occasion, Dr. Philip Lee, chairman of the Physician Payment Review Commission (PPRC), also testified. Based on that testimony, we were pleased to learn that some of the concepts that have been proposed by the College are likely to be included in the recommendations made by the PPRC as well.

THE VOLUME ISSUE—PLAN FOR MODERATING EXPENDITURE GROWTH

Mr. Chairman, if serious steps are to be taken to moderate spending for Medicare services, including the services of surgeons, then some workable approach must be found to strike a better balance among fee considerations, increases in volume and intensity, and the financial protections afforded beneficiaries under the program. This, it seems to us, is far more important than focusing attention almost exclusively on how payments should be distributed among different categories of physicians.

If we are going to be realistic, Congress must recognize that spending for health care probably will continue to rise, even if all hospital and physician payments were to be frozen at today's price levels. After all, the total number of Medicare beneficiaries is increasing every year, and the average age of the older population in this country also is rising, so that the demand for medical attention from the elderly can only be expected to increase as well. Moreover, changing medical technologies, better diagnostic techniques, and improvements that enhance the quality of life for older patients also contribute to increased Medicare spending for health services, and few would suggest that the aged—but not the young—should forgo these benefits. The major policy problems for the Congress, as we see it, are to determine by how much spending growth can be moderated without serious consequences for aged patients and whether such costs can be made more predictable.

Up to now, two general methods for reducing health spending have been discussed—either reducing the unit prices (or fees) of physicians' services or reducing the volume of those services.

The volume of physicians' services obviously reflects judgments about medical necessity that are influenced by the state of medical knowledge, and also, in part, by the professional liability climate. We believe that more physician-developed standards and guidelines are needed to define office and outpatient practice patterns relating to specific diseases, such as those that have been developed for a number of operations provided in inpatient settings. Criteria also are needed to make reasonable judgments about the frequency, volume, and effectiveness of both procedural and non-procedural physician activities. Ultimately, if guidelines are to influence the volume issue, it will be necessary to directly link payment policies with professionally developed criteria concerning the appropriateness and the effectiveness of various medical and surgical treatments. Our plan is premised on the establishment of such a linkage for surgical services provided to Medicare patients.

Those of us in surgery believe that it is impossible to effectively and efficiently address the volume issue across the entire spectrum of medical services. In most major hospitals, the responsibility for quality assurance and volume issues is assigned to specific departments with the experience and competence to deal with these issues in the context of specific service categories. It is for this reason that we propose an attempt to address the issue of increased volume of services exclusively within the scope of the specific specialty. At the present time, the volume of services paid for by Medicare is increasing at a rate that exceeds the increase in the aged population. In our view, Medicare will have greater success in dealing with this issue if the program follows the present examples within the medical profession for evaluating the appropriateness and quality of services.

We believe that major steps can be taken now to moderate the growth in Medicare spending, if the government will join with the surgical profession to make such a plan work. Working with the government, we are prepared to develop criteria to determine the appropriateness of various surgical treatments and to assist, as appropriate, in applying such criteria to determine payments for those services under Medicare. Furthermore, we are prepared to help identify unnecessary, outdated, or inappropriate services on a specialty-by-specialty basis.

In addition, we suggest another tool for moderating the expenditures for surgical services. Under this approach, the Secretary of Health and Human Services would calculate actual program expenditures for surgical services in a base year—perhaps 1989. From these amounts, the Secretary would be directed to determine on a budget-neutral basis a surgery-specific conversion factor that would be applicable to Medicare surgical services, using a new, blended fee schedule for Medicare surgical procedures to be described later in this testimony. Under the plan, this 1989 conversion factor would be updated for 1990 so as to remain budget neutral with respect to any expenditure goals for Medicare set forth by the Congress for that year. For 1991 and each year thereafter, the conversion factor would be increased to reflect changes in the costs of surgical practice, including professional liability costs, and changes in the general earnings levels of other comparable professionals.

The Secretary would be required to determine a national expenditure target for surgical services subject to the blended surgical fee schedule. In estimating this expenditure target for 1991, the Secretary, in consultation with representatives from beneficiary organizations and professional organizations of surgeons, would be required to take into account:

—population changes, including the total number of beneficiaries covered by Medicare, the age distribution of the enrolled population, and factors affecting morbidity;

—cost changes, including costs relating to the increased use of new technologies, and cost changes reflected in a market-basket index of practice costs (e.g., expenses for professional liability insurance) relating to surgical services; and

—estimated changes in the expected demand for and volume of surgical services that are required by Medicare patients.

Starting in 1994, if the Secretary finds that the estimated expenditure target for surgical services covered under the plan—taking into account the factors just described—would yield a significantly lower conversion factor than would result from the process used to update the blended fee schedule, he would be required to submit to Congress recommendations for adjusting future updates in scheduled payment amounts applicable in later years. In the event that the Secretary makes such a finding, he would be required to consider the views of the PPRC, the surgical community, and beneficiary organizations in developing his recommendations.

We believe that a thirty-six month interval between the effective date of the first phase of the plan—i.e., use of the blended surgical fee schedule—and the setting of the first target expenditure goal is needed in order to develop the infrastructure and data base within the surgical community that would be required for an effective program of volume assessment and compliance with professional standards. We are prepared to make a commitment to develop the needed infrastructure within the surgical community to make this plan work.

Mr. Chairman, we were pleased to learn that the PPRC also supports the concept of expenditure targets. However, there is a significant difference between the approach advocated by the PPRC and that recommended by the College. Whereas PPRC suggests a single target at the national level, the College believes that separate expenditure targets should be established on a specialty-specific basis, including at a minimum a separate target for surgical services.

PATIENT PROTECTION PROVISIONS

Mr. Chairman, the principal purposes of the Medicare program are to provide our older citizens with access to high quality medical care and with reasonable economic protection against the costs of those services. We believe that major changes in payment policies under the program for hospital and physicians' services must be considered with these goals in mind. We note that the PPRC also is concerned about beneficiaries' financial burdens under any new payment approach for physicians' services under Medicare. Mr. Chairman, you will note some similarities between the Commission's recommendations in this area and those of the College.

As you know, a significant number of our members and other physicians are participating physicians under Medicare and currently accept assignment in all Medicare cases. A much larger number of physicians, who have some objections to signing participation agreements, nevertheless frequently accept assignment for older patients, and particularly for those with more limited means. Thus, it seems appropriate to reexamine Medicare's current assignment experience and consider ways to improve the financial protection for surgical services afforded by Medicare under a new payment approach. Physicians wishing to sign participation agreements or to accept assignment in any other cases would be allowed to continue to do so under our plan.

Under the plan we propose, surgeons—working with beneficiary organizations and with the Congress—are prepared to support changes in the current assignment procedures under Medicare. One of these changes would involve the establishment by Congress of a national income level below which the new Medicare schedule of fees for surgical services would be considered as payment in full. Medicare would pay physicians 80 percent of the scheduled payment directly and the patient would remain liable for only the 20 percent coinsurance. No additional charges to qualifying patients could be made. Physicians would be permitted to charge their regular fees for all other patients, subject to Medicare's existing rules.

There are obviously some administrative considerations that would need further study to avoid claims problems for physicians and to protect the privacy of patients. But we believe that these difficulties can be overcome in a workable manner and are prepared to discuss a number of options with Congress about how to implement such a plan.

The College further believes that Congress also should consider the assignment rules affecting patients who have no opportunity to exercise their choice of surgeon, as in the case of a patient who has an acute illness and who requires emergency surgical services. Where no choice of a surgeon is available, the patient has no real opportunity to obtain the most favorable fee options, so that some patient protection against higher charges might seem warranted in such cases. We are now studying this proposition in more detail, but are not as yet prepared to recommend a specific way to address this issue.

Lastly, Mr. Chairman, we are concerned about the effects of any new valuation process that results in Medicare paying an above-market current price level for services and, thereby, potentially increasing the costs of those services for patients and, perhaps, the government, too. For example, if increases were to be made in Medicare's allowed amounts for some services, but not made in the maximum allowable actual charges that also apply to those services, the effects on patients will be mixed. The coinsurance costs for all patients for these services will rise, though any extra billing costs for non-assigned claims would be reduced. The premium costs for all enrollees also will increase as well. Thus, we believe that Congress should take steps to ensure, in some clear fashion, that Medicare patients benefit from steps that increase Medicare payments for certain services so that beneficiaries will not be unduly burdened by also paying a substantially larger copayment.

BLENDED FEE SCHEDULE FOR SURGICAL SERVICES

Mr. Chairman, an integral element of this proposal provides for the establishment of a blended fee schedule for surgical services under Medicare that would strike a balance between both supply-side and demand-side factors in determining relative values for the services covered under the proposed plan.

We wish to make clear that we support the use of a relative value scale in any Medicare fee schedule system. However, as the members of this Committee know, the College has major concerns about the use of a resource-based approach as the sole basis for establishing the value of services in such fee schedules. In general, we have felt that, among other things, this approach simply does not take into account the greater diagnostic or therapeutic value of specific services for patients, it ignores the quality of the services provided, and it fails to consider other factors that play a major role in determining the value of most other goods and services that are purchased in our society.

Moreover, no relative value scale, including the Harvard approach, offers any real solution for moderating the costs of medical and surgical services under the program. In fact, one of the effects of the Harvard RBRVS could be to raise Medicare fees paid to some physicians well above the levels they now charge or are paid by other private insurers for providing the same services. As we have noted, we believe that this would significantly increase the costs of those services not only for the government, but also for patients through higher premium and coinsurance costs. It also seems to us that substantial increases in payments for any services not only would increase the unit cost of those services, but also would provide strong financial incentives to increase the volume of these services. Without a plan for dealing with these volume effects under a resource-based approach, we believe Medicare costs would rise even more rapidly than they have in the past.

On the other hand, the major relative value reductions proposed under the RBRVS approach, including the effects on many procedural services, could seriously affect access to some physicians' services and reduce the interest of many physicians in signing Medicare participation agreements or accepting assignment.

We want to make it very clear, however, that we do not oppose using supply-side considerations, or resource input costs, as one factor in determining the value of services provided by physicians. Obviously, all physicians must carefully take into account such matters as their costs of practice when they establish their fees. Surgeons, for example, are especially aware of the effects of professional liability costs on the fees they must charge patients for their professional services. But, we believe that relying exclusively on physicians' judgments about the input costs of services in order to set relative values is conceptually incomplete. We also believe that there are special problems in surgery, such as professional liability costs, that need to be considered carefully in constructing any cost of practice adjustments in fees for surgical services. To that end, we strongly support the PPRC's expected recommendation that professional liability insurance premiums should be treated as a separate practice cost factor under any new Medicare fee schedule.

Therefore, we propose the development of a fee schedule for surgical services that would take into account not only the supply-side considerations reflected in a resource-based approach to payment, but also important demand-side considerations and the interests of patients that should not be ignored in the process of setting values.

To start, we believe that the Congress should consider legislation authorizing the Secretary to establish an explicit list of surgical services now provided to Medicare patients that would form the basis of a new approach to payment for those services. Non-operative invasive procedures that may be provided by both medical and surgical specialists would not be affected by the plan. Thus, only the services that are typically provided by physicians with the necessary surgical training or experience to perform such services would be part of the plan we have in mind. On the basis of our preliminary study of Medicare data and the scope of this plan, we estimate that surgical services covered by the proposal account for about 30 percent of all expenditures for physician services under Medicare.

Under our proposal, we anticipate that further efforts will be made by the PPRC and the Secretary to improve upon the methodology used in the Harvard RBRVS project to yield a more valid set of estimates of the resource costs involved in producing physicians' services. We also anticipate that recommendations will be made concerning those aspects of the Harvard RBRVS project that need further refinement, as well as the aspects that can be implemented more quickly. This is of concern to us, since not all of the surgical specialties were included in the initial phase of the Harvard project. Moreover, some of the results from the first phase need to be reexamined before the RBRVS results could be used.

We also believe that the Congress should direct the Secretary to conduct research into those factors that should be used to establish demand-side considerations affecting relative values for surgical services, including such possibilities as looking at market prices for services, the efficacy of alternative treatments as measured by data on such matters as mortality reduction and adverse consequences of treatment, and the importance of treatments to patients. Even the Harvard researchers seem to think there is merit in looking at physician charge data as a basis for making relative value calculations within different families of physicians' services.

We do not think that you will have to wait very long for the results of the Secretary's work in this area in order to identify and develop the kinds of information needed about demand-side considerations to determine relative values for the services that would make up a new Medicare fee schedule for surgery. The results of the Secretary's investigations in this area would be used to develop a new, blended schedule for surgical services provided to Medicare patients that would be applied as early as January 1991. Should the Secretary's work on demand-side factors not be ready by that time, we believe that physician charges could be used in the interim as a "rough" approximation of demand considerations.

In our view, the relative values of all physicians' services should be based on a composite of supply-side and demand-side values using equal weighting of both factors. However, we obviously cannot speak for other physicians on this point and, therefore, have limited our recommendations for a "blended" approach only to those services performed by surgeons.

PHASED IMPLEMENTATION

Mr. Chairman, we believe that rapid implementation of major payment reform changes could adversely affect patients by increasing some of their costs or perhaps by limiting their access to services. Thus, we have urged this Committee and other policymakers to proceed carefully and in stages to bring about significant changes in payment policy. These considerations suggest that major reform actions should be put in place over a reasonable transition period. We have developed a preliminary implementation schedule for our proposals consistent with these goals.

The major changes for which phased implementation seems appropriate are, first, to substitute the blended fee schedule for surgical services for the current reasonable, customary and prevailing fee-based methodology and, second, to implement the expenditure target program, including the development and application of criteria for judging the appropriateness and effectiveness of surgical services.

As noted above, the blended fee schedule for surgical services would be developed for use beginning in 1991. Under the plan, movement toward the full 50/50 blend of supply-side and demand-side considerations would commence in that year and be completed by 1996. In the interim, relative values based on current charges would be phased in with the new, blended values calculated by the Secretary for Medicare surgical services. The weight assigned to the new, blended values would increase steadily during the transition period, while the weight assigned to current charges would decrease gradually, as follows:

Year	Current charge weight	Blended schedule weight
1990	6/6	0
1991	5/6	1/6
1992	4/6	2/6
1993	3/6	3/6
1994	2/6	4/6
1995	1/6	5/6
1996	0	6/6

We believe that a less lengthy schedule is needed for phasing in geographic differentials under a blended fee schedule, with three years perhaps being a realistic goal after the data became available to make such adjustments. Both the differential used under Medicare's current methodology as well as a differential used under a reformed approach would be used. A composite rate of the two differentials would be calculated and phased in as follows:

Year	Current differential weight	Reform differential weight
1990	3/3	0
1991	2/3	1/3
1992	1/3	2/3
1993	0	3/3

We have not proposed a specific transition schedule at this time relating to the volume of services issue. We recognize, however, that the expenditure target provisions contained in our plan place the responsibility squarely on the surgical community to develop effective criteria for determining the appropriateness of care and for obtaining compliance with those criteria. Thus, we propose that the Secretary, after receiving further advice from the PPRC, from organizations representing surgery, and from groups representing beneficiaries, develop a reasonable schedule for implementing proposals relating to volume.

SUMMARY

In conclusion, Mr. Chairman, we are recommending a comprehensive plan for addressing the pricing and volume of surgical services under Medicare, and for providing important, new beneficiary financial protections. The key features of our plan are:

1. A fee schedule for surgical services under Medicare based on a 50/50 blend of resource costs and demand-side factors, effective in 1991;
2. An increased emphasis on the development, dissemination, and application of practice guidelines, coupled with a determination of a national expenditure target for surgical services, effective in 1994;
3. Payment for services provided to Medicare patients with incomes at or below a level determined by Congress on the basis of the scheduled payment amounts only; and
4. Phased implementation of the new payment system, beginning in 1991.

We fully intend to develop our proposals in greater detail. American surgery is committed to a constructive role in advising and participating with the Congress, the PPRC, and the Secretary in developing the initiatives that are necessary to moderate costs and to maintain the quality of, and access to, surgical services. The specific concepts presented in this proposal have been discussed with the leaders of ten surgical specialties. They have unanimously agreed to the formation of a Conjoint Council on Surgical Services to assist in further refinement of this action plan. These societies are:

American Academy of Ophthalmology
American Academy of Orthopaedic Surgeons
American Academy of Otolaryngology—Head and Neck Surgery
American Association of Neurological Surgeons
American Association for Thoracic Surgery/The Society of Thoracic Surgeons
American Pediatric Surgical Association
American Society of Colon and Rectal Surgeons
American Society of Plastic and Reconstructive Surgeons
American Urological Association
The Society for Vascular Surgery/International Society for Cardiovascular Surgery

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RESPONSES TO QUESTIONS SUBMITTED BY SENATOR PACKWOOD

Question. What indications do you have that your proposed blended fee schedule would differ substantially from the current system for paying surgeons? If it does not differ, why should Congress bother to make this change?

Answer. The College has had major concerns about the use of a resource-based approach as the sole basis for establishing the relative values of physicians' services under a Medicare fee schedule. We believe that, among other things, reliance on physician judgments only about input costs simply does not take into account the greater diagnostic or therapeutic value of specific services for patients. Concern is frequently expressed that some services are of marginal patient benefit. Basing relative values on input costs alone supports services of marginal value equally with clearly life-saving services. An RBRVS also fails to consider other factors that play a major role in determining the value of most other goods and services that are purchased in our society.

We believe that a blended fee schedule—which takes into account a balance of demand and supply considerations—would yield relative values that do differ from the implicit values for some services, in some areas, that exist under the current "usual and customary" approach to payment which probably overvalues marginal services. The magnitude of any changes, of course, could only be determined after actual relative weights were assigned in developing the blended schedule compared with charged-based values.

Question. We are faced with saving $2.7 billion from Medicare this year and perhaps even more in future years. The proposal you suggest proposes to postpone any real savings for at least 3 years and maybe 5 years. Since we have a proposal in hand that offers some ways to save money now, why should we wait?

Answer. The College urged the Physician Payment Review Commission (PPRC) to support an expenditure target plan in order to find ways of addressing expenditure problems relating to the volume, as well as the price, of physicians' services. Our recommendations, however, recognize that no infrastructure as yet exists to implement a comprehensive expenditure target plan applicable to all physicians' services. Thus, we have proposed to establish a plan that affects surgical services, where a process for assessing the appropriateness of services already exists and could be rapidly developed. We recognize, of course, that Congress has budgetary problems that must be addressed as well. If Congress would approve the elements of our expenditure plan this year, we are prepared to work with the Government to begin implementing the expenditure target program as rapidly as possible.

It is not clear to us, from the question, exactly what proposal you now have "in hand that offers some ways to save money now." Certainly, adoption of a relative value scale does not achieve the goal of cost containment and, in fact, could actually lead to additional increases in spending for physicians' services because it may induce increases in volume.

Question. I understand why only surgeons should review the work of other surgeons. But why should surgeons be paid using a different type of fee schedule than used for other physicians? Are you arguing that the demand side of your fee schedule should apply only to surgeons?

Answer. We believe that any valuation process should consider more than input costs alone, and that demand and supply considerations should be taken into account to establish the value of all physicians' services.

Question. If the fee schedule adopted for all physicians included "demand," would the American College of Surgeons support a fee schedule for all physicians? If not, why not?

Answer. Yes.

Question. The American Association of Retired Persons endorses the PPRC recommendation to have physicians bill Medicare directly. Could you give me your views on how physicians will respond to this proposal? Would their response differ depending on whether physicians could bill patients for the filing costs?

Answer. The vast majority of Medicare claims for surgeons' services are already filed directly by surgeons. The College also supports any steps that will ease administration of the program—for patients and for physicians—including improvements in Medicare's current paper-driven claims process. Nevertheless, a requirement that physicians must file all claims may increase benefit and the administrative costs of physicians' practices that should be borne by the Medicare program.

COMMUNICATIONS

STATEMENT OF THE AMERICAN ACADEMY OF NEUROLOGY

The American Academy of Neurology (AAN) appreciates this opportunity to express the views of neurologists nationwide on reform of the system Medicare uses to pay for physician services, and particularly to respond to the proposals recently released by the Physician Payment Review Commission (PPRC).

The Academy is a national association representing over 10,000 neurologists and neuroscientists. We have been involved in the Commission's efforts to reform physician payment under the Medicare payment system since the inception of PPRC. We would like to take this opportunity to inform this Committee of our views and concerns regarding the establishment of a fee schedule based on a resource based relative value scale, and other issues the committee will be addressing as a result of the PPRC's recommendations in its annual report.

IMPLEMENTATION OF A PAYMENT SCHEDULE

The Academy, through its representatives on one of Harvard's Technical Consulting Groups, has been an active participant in the Harvard Resource-Based Relative Value Scale (RBRVS) project.

We certainly share the enthusiasm and belief that the RBRVS will be positive for medicine and Medicare beneficiaries in its overall impact in re-aligning the incentives for the provision of care. Moreover, we believe that the RBRVS study is a major step forward in reforming the way physicians are reimbursed under Medicare.

The Academy recognizes that there are limitations to the Harvard RBRVS study, and believes that it needs to be sufficiently refined, corrected and expanded to be an acceptable basis for reform. We are aware of the work the PPRC is doing to help improve, and refine some of the inadequacies of the Harvard study. Such efforts, along with improvements the researchers are making in the second phase of the study, particularly the inclusion of neurology and other specialties in the second phase, will produce a more satisfactory basis for a resource-based payment schedule. At that time we believe we will be in a position to endorse, unreservedly a payment schedule based on the RBRVS study.

One aspect in particular of the Harvard study that the Academy would like to see more fully addressed is the absence of mechanisms to recognize and measure the complexity of cases treated by specialists such as neurologists. Other concerns, including the treatment of practice costs; estimations of pre- and post-service work; the measurement of resource costs for evaluation and management services; and the identification and measurement of case mix are all issues that neurologists would also like to see evaluated more carefully.

ISSUES ASSOCIATED WITH A PAYMENT SCHEDULE

Coding Reform of Evaluation and Management Services

The Academy is particularly concerned with issues relating to the reform of coding for evaluation and management services such as visits and consultations. This is the subject of significant interest to neurologists because such codes are mainly used to identify the care we provide to our patients.

The AAN supports the PPRC's study of physician coding and its analysis that a coding system should provide data that more accurately represents medical services provided to a patient. The Academy also agrees with PPRC's analysis that the coding requirements of a resource-based fee schedule are unique in that a coding system must take into account time, effort, and intensity expended by a physician in performing a medical service. The Commission found that CPT visit codes do not uniformly represent the amount of time and work expended in performing a medical service. We agree that there is variation in how neurologists and other physicians use and interpret CPT codes for the services they provide.

The Mendenhall study, referred to in the Commission's report as the USC study, found, among other things, that neurologists have the longest patient encounter time of any of the medical specialties involved in ambulatory care. Therefore, the study directly relates to the difficult and complex nature of a neurological examination and the need to have appropriate coding to recognize the time and effort expended to complete such an examination. The AAN supports a method of coding that would incorporate time in the definition of levels of service and would lead to the development of more accurate values for evaluation and management (EM) services based on the estimated relationship between work and time. This method would also be compatible with the current coding system.

We are concerned, however, that the Commission is too heavily dependent on time as the major factor in describing the levels of evaluation and management services. The Academy believes that factors other than time (such as more highly defined components of physician work, complexity of care provided and severity of illness) are extremely important to be included in the coding system. However, any changes in the coding system should ultimately reflect the actual services rendered to the patient—and should not simply be a function of time and effort. Time is an extremely important factor, but the Academy envisions a coding system that incorporates a description of specific services as well as time in the definitions for evaluation and management services. These definitions would help ensure equitable payment for more efficient physicians and will facilitate carrier verification. Although the Commission has also stated this, we are concerned that this point is not made as clearly as it should be or with enough emphasis. We hope that when Congress implements payment reform, it keep in mind the need, down the road, to be able to incorporate these important factors in any payment system that is developed.

The Commission's second recommendation to Congress regarding evaluation and management services—to delay the legislative mandate to group codes for payment purposes until reform of coding for evaluation and management services is completed is a good one. The Academy supports it fully. It is in keeping with our belief that until the coding system has been revised to reflect accurately the services provided and the resource costs expended, no interim changes to the system should be made. The Academy believes that such changes may serve only to hamper efforts underway to move toward a more rational system of defining and paying for physician services.

Specialty Differentials/Amortized Cost of Specialty Training

Another area of specific concern to the Academy is the action the Commission has taken with respect to the different resource costs expended by various specialties. The Commission makes the recommendation that specialty differentials should not be incorporated into the Medicare fee schedule. Although the Commission is correct in stating that if the coding system were revised appropriately, there may not be any need for differentials, the AAN does not believe that the Commission has adequately shown that what is planned in the way of coding changes will in fact identify differences among physicians in the resource costs required to provide the evaluation and management services typical for their specialty. Without certainty that coding will improve, nor without any assurances that complexity of care and severity of illness modifiers will be reflected in the changes, the Commission is making a premature assumption when it specifically opposes specialty differentials. We believe that this recommendation is premature and Congress should not act to implement such a provision in the fee schedule until such time as revised CPT codes for evaluation and management services have been developed.

Attendant to the above consideration, AAN is also concerned that the Commission has dropped the specialty training cost factor (AST) from the equation for the RVS. The reasoning behind the Commission's approach also seems premature. The PPRC has stated that it believes that physicians should be paid the same when the service is the same. The Academy believes that until the Commission can show that complexity of care and severity of patient illness are included in the coding system, we cannot know that the service is the same. In fact, the Academy, in its previous testimony presented to the PPRC, has emphasized the uniqueness of a neurological examination. To perform such an examination requires special training and expertise in neuroanatomy, neurophysiology, and the subsequent formulation of an appropriate diagnosis with a plan for therapy. The examination is complex, and understanding the results of the examination requires special training not usually acquired in medical school.

The procedure code for a neurological examination should be a modifier of the basic procedure because it is a completely different procedure and not a standard examination. This would be applicable to consultation, at various levels, initial and/or hospital visit. The basis for this statement derives from the Mendenhall of "USC" study performed in 1977.

The log-diary survey currently underway will help provide data as to the different case mix and resource costs provided by at least some different specialties. We believe the Commission is prematurely assuming that these differences will be addressed. If neither specialty differentials nor specialty training costs are reflected in the RBRVS the Commission, and Congress, if it adopts these recommendations, is asking physicians such as neurologists to accept, on faith, that a future coding system will address these differences.

Expenditure Targets/Practice Guidelines

AAN is concerned that the Commission again has acted prematurely in calling for expenditure targets after the first year of a RBRVS fee schedule. The AAN shares Congress' concern to moderate the rate of growth of Medicare expenditures. The difficult question is how to limit growth without threatening the quality of care or moving towards a system of "rationing" care. The quality of patient care and the access to care must not be jeopardized under any kind of Congressional budget-cutting plan. The Academy opposes expenditure targets as an inappropriate method to reduce Medicare expenditure growth.

The Academy supports continued studies and efforts to develop outcome assessment and practice guidelines. Until practice parameters and outcome assessment research can tell us what is appropriate care, expenditure targets will serve no policy purpose in reducing outlays.

The Academy has begun a quality standards program and there is strong organizational commitment to setting guidelines for neurologic care. The Academy feels it is imperative that neurologists participate in the development of practice guidelines for neurology.

Mandatory Assignment

The Academy is pleased to see the Commission recommend against mandatory assignment. The Academy believes that a payment schedule based on a RBRVS should not be linked to mandatory assignment. We believe that low-income beneficiaries should be protected from charges they cannot afford, but the voluntary assignment option should be maintained. The Academy supports appropriate limits on balance billing to low-income beneficiaries. The PPRC's proposal to require acceptance of assignment for all individuals whose costs are shared by state Medicaid programs is consistent with this principle. The Academy is concerned about access for patients needing neurological care, and has established an Access to Neuro-Care Task Force. This Task Force is exploring steps neurologists can take to assure that indigent patients have access to high quality neurologic care.

Since the data show that doctors generally consider individual patients' financial needs when determining their fees, the Academy believes that mandatory assignment is unnecessary. In addition, we believe there are other more positive ways to increase assignment than by mandating it. The current high assignment rate of charges (78.7%) could be even higher if the government would correct substantial problems with Medicare. If Medicare would increase its reimbursement levels, particularly for evaluation and management services, physicians would, we believe, be more likely to accept assignment for that service.

The Commission's draft paper on "PPRC Beneficiary Survey" indicates a larger problem with respect to assignment policy that needs to be addressed. A majority of Medicare beneficiaries do not know their options and rights under the Medicare program. They do not know what Medicare should pay for, what they must cover out-of-pocket according to law, or even that they can ask their doctor not to charge more than the Medicare allowed charge.

All of this data speaks to the need for better education of beneficiaries as to their options and rights under the Medicare program. Physicians are clearly responsive to the financial and health concerns of their patients, but more needs to be done. The Academy strongly believes that mandatory assignment is not the answer, but that much can be done to help close the gaps for the small percentage of poorer and sicker patients rather than mandating across-the-board assignment. The ability of patients and physicians to contract for services at a price that varies from the Medicare allowed charge must be preserved under a RBRVS payment schedule.

Under a schedule of allowances beneficiaries will be able to predict in advance how much Medicare will pay for a given service. They will then be able to compare that allowance with the physicians' actual charges to predict more effectively their out-of-pocket liability for the services. Consequently, the Academy believes that patients should have the freedom to choose a personal physician they think offers a higher level of skill or experience and who may appropriately charge more.

Conclusion

In conclusion, the AAN urges Congress to establish policies that will (1) provide a scientific basis for controlling the volume of inappropriate services; (2) protect low-income beneficiaries from charges they cannot afford, while maintaining the availability of the individual assignment option; and (3) establish a payment schedule that recognizes through coding or some other fashion, the additional resource costs expended by neurologist's and other specialists in providing care to their patients.

STATEMENT OF THE AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS

SUBMITTED BY NEWTON C. MC COLLOUGH, III, PRESIDENT

Mr. Chairman and members of the Sub-Committee, I am Newton C. McCollough, III, M.D., President of the American Academy of Orthopaedic Surgeons, Director of Medical Services for Shriners Hospitals for Crippled Children, and a professor of orthopaedic surgery at the University of South Florida.

The American Academy of Orthopaedic Surgeons appreciates the opportunity to comment on various physician reimbursement issues before Congress.

The Academy shares the concerns of the public and the Federal government about the rising costs of health care in America, and wants to participate actively in developing effective cost-containment strategies. However, we recognize that these strategies must be developed and implemented in a way which does not compromise the quality of health care.

In our testimony today, we wish to discuss the following issues:

1. The Proposed Resource-Based Relative Value Scale;
2. The Implementation Period for a New Medicare Fee Schedule;
3. Professional Liability Expenses in Relation to Medical Practice Costs and Physician Fees;
4. Physician Acceptance of Medicare Assignment for Low-Income Families;
5. Improving the Standardization of Coding and Billing Practices;
6. The Possible Use of Medicare Expenditure Targets; and
7. Identification and Elimination of Ineffective and Inappropriate Medical Practices.

1. The Proposed Resource-Based Relative Value Scale (RBRVS)

We believe that the proposed RBRVS seriously misrepresents the value of orthopaedic services relative to other medical services. Furthermore, the RBRVS *will not* address the concerns of the medical profession and the Federal government about increasing health care costs, since it does not address the issue of volume control.

In addition to having serious methodological flaws, the RBRVS fails to consider important factors such as the severity and complexity of the patient's condition and the benefit/outcome (value) which the service provides to the patient. The Medicare fee schedule should be based on a substantially revised relative value scale, based on more accurately calculated resource costs, blended with historical fee data to provide an index of value.

Medicine and surgery are not industrial/production line activities. The art of medicine and the skill required to perform a service are not easily quantified as resources. The proposed RBRVS would shift billions of dollars from surgical care, where curative and restorative outcomes are clear, in order to increase the compensation for millions of encounters and services where volume constraints are not established by current methods and where the skills employed and patient benefits to be obtained are much more difficult to document.

We believe that the RBRVS is flawed in two major ways. First, the methodology for calculating the resource-inputs has serious shortcomings. Revisions are required, including:

- Pre- and post-service time estimates have methodological weaknesses and need further study;
- Cross-specialty links for orthopaedics often were not as successful as for other specialties; they need to be re-examined and possibly broadened;
- The vignettes used in orthopaedics may not be representative of the full range of services provided by the specialty and should be re-examined and revised;
- The extrapolation methodology used to project the surveyed services to non-surveyed services produced mixed results as seen in a comparison of the American

Medical Association data and the Harvard study data, and must be carefully analyzed.

A second major flaw is that basing the relative value scale strictly on resource inputs overlooks many important factors contributing to the value of a given service, such as its value to the patient or the quality of the service provided. Recognizing that these factors are not yet sufficiently developed to use in a fee schedule, we support a blended relative value scale, based on an improved RBRVS together with existing physician charges, used as a rough approximation of the value of services to the consumer.

2. The Implementation Period for a New Medicare Fee Schedule

We urge a gradual implementation of the new Medicare fee schedule. The two-year implementation period proposed by the Physician Payment Review Commission (PPRC) is not long enough to accomplish the necessary revisions or to accommodate the serious impact on many orthopaedic practices that will result if we are subjected to payment cuts of up to 72 percent for some procedures.

The Academy has recently reviewed a procedure-by-procedure description of the impact of the proposed RBRVS on orthopaedics. The impact is staggering, with reduced payments ranging from 30–72 percent for many common orthopaedic procedures. This degree of reduction could have a significant impact on our continued ability to treat the uninsured patients who need and deserve attention. Our recent practice survey indicates that over 70 percent of orthopaedic surgeons regularly provide care for patients from whom they neither expect nor receive compensation.

In order to avoid a catastrophic impact on the organization and viability of thousands of orthopaedic practices, their employees, and the availability of community services, we recommend a much longer phase-in period than the PPRC's two-year period. A gradual implementation period will permit necessary practice reorientation and stalling adjustments.

3. Professional Liability Expenses in Relation to Medical Practice Costs and Physician Fees

We believe that any new Medicare fee schedule should treat professional liability expenses as a separate item when determining practice costs as recommended by the PPRC, recognizing regional and specialty variations and the need for frequent updating.

Furthermore, it is our opinion that Federal initiatives to resolve the professional liability problem could result in substantial savings for Medicare and reduce the adverse impact of the proposed fee schedules on high risk specialties.

Given the volatility of the professional liability situation, we believe that any new fee structure must be extremely sensitive to the impact of professional liability insurance premiums on practice costs and physician fees. Expenses vary widely by geographic area, by specialty, and from year-to-year.

4. Physician Acceptance of Medicare Assignment for Low-Income Families

The Academy supports the concept of physician acceptance of assignment for low-income families. Over 53 percent of orthopaedic surgeons now participate in the Medicare program, and 91 percent of non-participating orthopaedists accept assignment on a case-by-case basis.

Like Congress, the Academy has a real concern for needy elderly patients and believes that the profession should express its willingness to accept assignment for patients with low income levels as we orthopaedists are already doing.

5. Improving the Standardization of Coding and Billing Practices

We support improved standardization of coding and billing practices, and we are working on defining the content of the PPRC's uniform global fee definition for orthopaedic surgical procedures.

Because individual Medicare carriers have different coding and billing policies, wide inconsistencies exist in coding and billing practices. We believe uniform policies could eventually help reduce Medicare expenditures, as well as the likelihood of abuse. To further these objectives, we also believe that the uniform global fee concept should be expanded to include procedures performed by non-surgical specialties as well.

6. The Possible Use of Medicare Expenditure Targets

The Academy cannot support the concept of expenditure targets at this time. We believe that extended and careful study of the concept needs to be undertaken to explore the potential impact on patient care and access and to assess whether sufficient data is available to establish targets. If expenditure targets are implemented in the future, separate targets should be used for surgical services as distinct from other services.

7. Identification and Elimination of Ineffective and Inappropriate Medical Practices

An alternative to expenditure targets as a way of controlling the volume of Medicare services is to begin identifying and eliminating ineffective and inappropriate medical practices. While methods to do this are in their infancy, many fledgling projects are underway. These projects, including practice guidelines, small-area variation studies, outcome studies, and technology assessment, would benefit from vigorous support by the Federal government and the private sector. We see this as the most rational approach to dealing with the volume of services issue from the provider standpoint.

Another approach to address burgeoning health care costs is to begin efforts to moderate the volume of services being demanded by the public. To continually restrict resources available to hospitals and providers without moderating demand for services will ultimately lead to a destruction of the finest health care delivery system in the world. Difficult as it may be, you must exert leadership and assist us in addressing the public and its demand for ever-increasing benefits coupled with its unwillingness to pay the reasonable cost of the services it desires.

Top 36 Medicare Expenditures

As a final point Mr. Chairman, we recently reviewed 1987 Health Care Finance Administration (BCFA) data on allowed services and allowed charges (See Attachment). Of the top 36 most costly services, six, totaling $2.9 billion for 120.4 million units of service, were for follow-up office or hospital visits designated as. limited, brief, or intermediate. These are the same areas targeted for substantial increases without corresponding volume controls. We believe this large volume of services and expenditures should be evaluated for content, need and effectiveness. The Congress, the Administration, and Medicine must develop mechanisms to determine if the Medicare patient is receiving a health benefit equal to the public dollar spent.

We believe that the Congress must ask what factors truly malke a difference in longevity and quality of life for our senior citizens. A timely evaluation of Medicare services is essential to determine if all of the billions of dollars being spent are for services and procedures of significant value to the patient. The Academy stands ready to assist in this type of endeavor.

We appreciate the opportunity to express our view on these physician reimbursement issues, and we look forward to continuing to work with you on these and other vital health care concerns.

ATTACHMENT

MEDICARE EXPENDITURES FOR 36 MOST FREQUENT PRACTITIONER SERVICES

Procedure Code	Description	Allowed Services	Allowed Charges
66984	Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or phacoemulsification technique	1,030,410	$1,503,453,494
90060	Office Medical Service, new patient; intermediate service	40,956,607	$1,034,712,140
90260	Subsequent Hospital Care each day; intermediate services	29,772,656	$ 878,984,997
90050	Office Medical Service, established patient; limited service	42,205,886	$ 858,929,877
90250	Subsequent hospital care, each day; limited services	23,514,348	$ 604,370,601
90620	Initial consultation; comprehensive	4,929,576	$ 447,901,822
90220	Comprehensive history and examination, initiation of diagnostic and treatment programs, and preparation of hospital records	5,672,370	$ 437,393,921
93000	Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report	9,610,604	$ 329,627,435
71020	Radiologic examination, chest, two views, frontal and lateral;	14,641,479	$ 318,617,333
52601	Transurethral resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)	255,471	$ 287,144,236
90070	Office Medical Service, established patient; extended service	8,615,177	$ 283,206,862
90270	Subsequent hospital services, each day; extended services	6,902,831	$ 267,586,089
90040	Office medical service, established patient; brief service	13,042,378	$ 222,178,650
93010	Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only	16,505,729	$ 203,086,593
90080	Office medical service, established patient; comprehensive service	3,972,181	$ 190,176,013
90020	Office medical service, new patient; comprehensive	3,085,313	$ 172,982,180
33512	Coronary artery bypass, autogenous graft, (eg, saphenous vein or internal mammary artery); three coronary grafts	62,762	$ 167,378,443
27130	Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip replacement)	92,100	$ 166,130,169
27447	Medial and lateral compartments with or without patella resurfacing (total knee replacement)	96,236	$ 164,982,258

MEDICARE EXPENDITURES FOR 36 MOST FREQUENT PRACTITIONER SERVICES

Procedure Code	Description	Allowed Services	Allowed Charges
71010	Radiologic examination, chest; single view, frontal	11,837,278	$ 162,483,025
90240	Subsequent hospital care each day; brief services	8,019,813	$161,632,653
92014	comprehensive, established patient, one or more visits	3,849,185	$151,294,081
90630	Initial consultation; complex	1,245,577	$ 149,800,117
43235	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; complex diagnostic	490,366	$ 148,898,512
33513	Coronary artery bypass, four coronary grafts	53,010	$ 148,837,936
93547	Combined left heart catheterization, selective coronary angiography, one or more coronary arteries and selective left ventricular angiography	203,079	$ 140,414,231
45378	Colonoscopy,fiberoptic, beyond splenic flexure; diagnostic procedure	328,647	$ 138,970,201
80019	Pathology and Laboratory, 19 or more clinical chemistry tests (indicate instrument used and number of tests performed)	7,751,248	$ 135,974,236
66821	Anterior segment — lens laser surgery (eg, YAG laser)	268,182	$ 129,736,192
45385	Endoscopy: for removal of polypoid lesion	190,565	$ 121,743,259
66983	Intracapsular cataract extraction with insertion of intraocular lens prosthesis (one stage procedure)	87,340	$ 120,975,983
92012	Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient	3,899,650	$ 116,673,174
27244	Open treatment of closed or open intertrochanteric, pertrochanteric, or subtrochanteric femoral fracture, with internal fixation	114,964	$ 116,213,249
90215	Intermediate history and examination, initiation of diagnostic and treatment programs, and preparation of hospital records	1,817,042	$ 109,846,446
99173	Intermediate examination, evaluation and/or treatment, same or new illness	2,210,031	$ 106,790,712
90280	Subsequent hospital care; comprehensive services	2,313,618	$ 106,284,272

STATEMENT OF THE AMERICAN COLLEGE OF RHEUMATOLOGY

The American College of Rheumatology appreciates this opportunity to express the views of rheumatologists nationwide on reform of the Medicare physician payment system, and in particular, to respond to the proposals recently released by the Physician Payment Review Commission (PPRC).

The American College of Rheumatology is the only professional organization of physicians and scientists devoted to the study and treatment of rheumatic diseases and the education of professionals who care for these disorders. The vast majority of its 500 members are rheumatologists.

A rheumatologist is a specialist who provides medical care to patients with arthritis, diseases of the immune system and other disorders that cause pain and inflammation of the joints, muscles, and bones. Osteoarthritis, rheumatoid arthritis, gout, systemic lupus erythematosus, bursitis, back pain, and osteoporosis represent some of the more than 100 types of rheumatic disease, which affect more than 37 million people in the United States and which are a leading cause of disability and absence from work in this country. By special training and expertise, rheumatologists are uniquely qualified among physician specialists to care for people with rheumatic diseases in a high quality and cost-effective manner, and to lead the team of health professionals who assist in treating these diseases.

The College has been involved in the Commission's efforts to reform physician payment under the Medicare payment system since the inception of PPRC. We have worked closely with Commission staff in addressing the issue for visit coding reform, and are participating in the log-diary survey. We would like to take this opportunity to inform this Committee of our views and concerns regarding the establishment of a fee schedule based on a resource based relative value scale and other issues the committee will be addressing as a result of the PPRC's recommendations in its annual report.

IMPLEMENTATION OF A PAYMENT SCHEDULE

The American College of Rheumatology believes strongly that a resource-based relative value scale (RBRVS) should be the basis for the development of a Medicare physician payment schedule. The College recognizes that there are limitations to the Harvard RBRVS study, but believes that when it is sufficiently refined, corrected and expanded, it will be an acceptable basis for reform. We are aware of the work the PPRC is doing to help improve and refine some of the shortcomings of the Harvard study. Such efforts, along with improvements the researchers are making in the second phase of the study, will produce a satisfactory basis for a resource-based payment schedule.

One aspect of the Harvard study that the ACR would like to see more fully addressed is the absence of mechanisms to recognize and measure the complexity of cases treated by subspecialists such as rheumatologists. Other concerns, including the treatment of practice costs; estimations of pre- and post-service work; the measurement of resource costs for evaluation and management services; and the identification and measurement of case mix are all issues that rheumatologists would also like to see evaluated more carefully.

TRANSITION PERIOD

The American College of Rheumatology believes that a transition period between the current Medicare system and any system involving a RBRVS payment schedule, while necessary, should be brief and determined by administrative considerations. A payment schedule based on the RBRVS should be implemented no later than January 1, 1991. In addition, the College believes that there should be periodic updates of the resource-based relative value scale, and any payment schedule based upon that RBRVS. Physicians must be appropriately represented and involved in this process.

ISSUES ASSOCIATED WITH A PAYMENT SCHEDULE

Coding Reform of Evaluation and Management Services

The College is particularly concerned with issues relating to the reform of coding for evaluation and management services such as visits and consultations. This is the subject of significant interest to rheumatologists because such codes are used virtually exclusively to identify the care we provide to our patients.

The College has been keenly interested in the Commission's work on this subject and has been actively working with the Commission in its efforts to examine the "visits" and levels of service issue. As one of the three specialties being evaluated as part of the log-diary survey, we anticipate that the results of the study will be extremely helpful in guiding the Commission toward decisions about coding refinements for evaluation and management services.

We are concerned, however, that the main emphasis of the Commission's recommendation and its report, is too heavily dependent on time as the major factor in describing physician work in the levels of evaluation and management services. The College believes that factors other than time (such as more highly defined components of physician work, complexity of care provided and severity of patient illness) are extremely important to be included in the coding system. Although the Commission has also stated this, we are concerned that this point is not made as clearly as it should be or with enough emphasis. We hope that when Congress implements payment reform, it keep in mind the need, down the road, to be able to incorporate these important factors in any payment system that is developed.

After reading the Commission's recommendations in the draft chapters of its 1989 report, the College is concerned that one might believe that incentives would be put into place to increase the volume of services. Physicians should not merely be able to have briefer and more frequent visits in order to increase their income. Such incentives seem distorted to the College. We believe that this emphasis is due to too much reliance by the Commission on a curvilinear relationship between work and time, "in which the overall amount of work per unit time is greater for shorter than for longer visits." Based on our members' knowledge of the services they provide, the College does not accept this relationship as a basis for coding—and subsequently payment—for evaluation and management services.

Rheumatologists are few in number. The data the Commission uses suggest to us that rheumatologists are probably outliers; patient encounters of rheumatologists do not fit that curve. The amount of work for the services we provide does not diminish with time. For example, due to the severity of illness of most of the patients we care for, the prevalence of a ten minute consultation is extremely rare. Such patient encounters are not within the norm of care provided by rheumatologists. We look to the results of the log-diary survey in which we are participating, to give us and the Commission a more factual basis upon which to rely—and to make judgments regarding the true components of physician work.

The College envisions a coding system that incorporates a description of specific services as well as time in the definitions for evaluation and management services. These definitions would help ensure equitable payment for more efficient physicians and will facilitate carrier verification. If CPT descriptors would continue to be refined to include elements describing the "content of services provided during the encounter, a more predictable and understandable coding system would be in place to address the complexity of care and/or severity of illness. Moreover, *if done properly, it would allow both physicians and carriers to have a system capable of being verified.*

This is particularly important for rheumatologists and their patients; in most parts of the country there is a lack of recognition by many Medicare and third-party carriers of rheumatologists as specialists separate and distinct from general internists. Many Medicare carriers do not recognize the rheumatologist as a specialist with unique training and expertise—having an expected predominance of more severely ill patients leading to a more severe case mix and the need to provide more complex care. Rheumatologists are included under the more general designation of internists. This has a number of adverse ramifications for rheumatologists and their patients, not the least of which is the carriers' inability to distinguish appropriate care provided by a rheumatologist from that of a general internist. For example, screens used by carriers for such things as gold injections, laboratory monitoring of such injections, number of visits, and number of "higher level visits" frequently are denied and moreover, cause inequities in payment for rheumatologists and their patients.

The Commission's second recommendation to Congress regarding evaluation and management services—to delay the legislative mandate to group codes for payment purposes until reform of coding for evaluation and management services is completed is a good one. The College supports it fully. It is in keeping with our belief that until the coding system has been revised to reflect accurately the services provided and the resource costs expended, no interim changes to the system should be made. The College believes that such changes may serve only to hamper efforts underway to move toward a more rational system of defining and paying for physician services.

Specialty Differentials/Amortized Cost of Specialty Training

Another area of specific concern to the College is the action the Commission has taken with respect to the different resource costs expended by various specialties.

The Commission makes the recommendation that specialty differentials should not be incorporated into the Medicare payment schedule. Although the Commission is correct in stating that *if* the coding system were revised appropriately, there may not be any need for differentials, the College does not believe that the Commission has adequately shown that what is planned in the way of coding changes will in fact identify differences among physicians in the resource costs required to provide the evaluation and management services typical of their specialty. Without certainty that coding will improve, nor without any assurances that complexity of care and severity of illness modifiers will be reflected in the changes, the Commission is making a premature assumption when it specifically opposes specialty differentials. We believe that this recommendation is premature and Congress should not act to implement such a provision in the fee schedule until such time as revised CPT codes for evaluation and management services have been developed.

Attendant to the above consideration, the College is also concerned that the Commission has dropped the specialty training cost factor (AST) from the equation for the RVS. The reasoning behind the Commission's approach also seems premature. The PPRC has stated that it believes that physicians should be paid the same when the service is the same. The College believes that until the Commission can show that complexity of care and severity of patient illness are included in the coding system, we cannot know that the service is the same. Patients for whom rheumatologists routinely provide care are more severely ill, and with more complex symptoms and comorbid illnesses than those of most other physicians who treat patients with rheumatic diseases.

The log-diary survey currently underway will help provide data as to the different case mix and resource costs provided by at least some different specialties. We believe the Commission is prematurely assuming that these differences will be addressed. If neither specialty differentials nor specialty training costs are reflected in the RBRVS the Commission, and Congress, if it adopts these recommendations, is asking specialists such as rheumatologists to accept, on faith, that a future coding system will address these differences.

Expenditure Targets/Practice Guidelines

The College is concerned that the Commission again has acted prematurely in calling for expenditure targets after the first year of a RBRVS payment schedule. Much of the testimony the Commission received (and much of the testimony Congress has received to date) discussed the fact that an infrastructure through which physicians will be able to limit volume does not currently exist. In addition, the information that is needed to ensure that reductions in volume are reductions in inappropriate services, not necessary care, will not be available for three to ten years. Without such crucial information, including ongoing outcome assessment research and the development of practice guidelines, the Commission's recommendation amounts to rationing of care.

Any payment reform system should be developed, at a minimum in a budget-neutral fashion. The appropriate way to reduce Medicare expenditures is to reduce inappropriate care. This can be done through the development and implementation of practice guidelines and outcome assessment research.

The College is in full support of the development of practice guidelines and increased funding for outcome assessment research. We found the Commission's draft chapter, "Effectiveness, Research and Practice Guidelines," to be on target regarding these issues and particularly the need for increased funding of such efforts.

Mandatory Assignment

The College is pleased to see the Commission recommend against mandatory assignment. We have testified to the PPRC on that issue to the same effect. The College believes that a payment schedule based on a RBRVS should not be linked to mandatory assignment. The College is opposed to mandatory assignment for several reasons, not the least of which is the lack of established need for it.

Since the data show that doctors generally consider individual patients' financial needs when determining their fees, the College believes that mandatory assignment is unnecessary. In addition, we believe there are other more positive ways to increase assignment than by mandating it. The current high assignment rate of charges (78.7%) could be even higher if the government would correct substantial problems with Medicare. We have stated to the Commission that we believe a payment schedule should be implemented at a minimum in a budget-neutral fashion. If Medicare would increase its reimbursement levels, particularly for evaluation and management services, physicians would, we believe, be more likely to accept assignment for that service.

Another reason physicians have been reluctant to accept assignment is because Medicare carriers frequently are not timely in processing claims. Lengthy delays in reimbursement can leave physicians, particularly those with high patient loads, with considerable overhead to cover. Even without balance-billing, a physician may wish to not accept assignment so that he can protect his cash flow and pay for his overhead.

The Commission's draft paper on "PPRC Beneficiary Survey" indicates a larger problem with respect to assignment policy that needs to be addressed. A majority of Medicare beneficiaries do not know their options and rights under the Medicare program. They do not know what Medicare should pay for, what they must cover out-of-pocket according to law, or even that they can ask their doctor not to charge more than the Medicare allowed charge.

All of this data speaks to the need for better education of beneficiaries as to their options and rights under the Medicare program. Physicians are clearly responsive to the financial and health concerns of their patients but more needs to be done. The College strongly believes that mandatory assignment is not the answer, but that much can be done to help close the gaps for the small percentage of poorer and sicker patients rather than mandating across-the-board assignment. The ability of patients and physicians to contract for services at a price that varies from the Medicare allowed charge must be preserved under a RBRVS payment schedule.

Under a schedule of allowances beneficiaries will be able to predict in advance how much Medicare will pay for a given service. They will then be able to compare that allowance with the physicians' actual charges to predict more effectively their out-of-pocket liability for the services. Consequently, the College continues to believe that patients should have the freedom to choose a personal physician they think offers a higher level of skill or experience and who may appropriately charge more.

Conclusion

In conclusion, the American College of Rheumatology urges Congress to establish policies that will (1) mandate a payment schedule based on the RBRVS for implementation no later than January 1, 1991; (2) provide a scientific basis for controlling the volume of inappropriate services; (3) protect low-income beneficiaries from charges they cannot afford, while maintaining the availability of the individual assignment option; and (4) establish a payment schedule that recognizes through coding or some other fashion the additional resource costs expended by rheumatologists, and other specialists in providing care to their patients.

STATEMENT OF THE AMERICAN PSYCHIATRIC ASSOCIATION

The American Psychiatric Association, a medical specialty society representing more than 35,000 psychiatrists nationwide, is pleased to submit this testimony to the Senate Finance Committee's Subcommittee on Medicare and Long-Term Care. Your task is an enormous one and hopefully our testimony will elucidate issues related to psychiatry and physician payment reform.

Our testimony reviews for you APA's analysis of the Harvard Resource-Based Relative value Study and, some concerns and positive views we have about areas of the Physician Payment Review Commission's recommendations to Congress. Prior to beginning the discussion of the reaction to some of the proposals we believe it important to highlight the discriminatory limitations for patients with "Mental, Psychoneurotic, and Personality Disorders". These arbitrary limitations were improved for the first time in OBRA 87 due to the fine work of many members of your subcommittee.

MEDICARE COVERAGE FOR "MENTAL, PSYCHONEUROTIC, AND PERSONALITY DISORDERS"

The Medicare program outpatient benefit for patients with mental disorders was limited to an arbitrary $250 (after an effective 50% copayment) from the inception of the Medicare program until the recently approved changes included in the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203). A special exception was made administratively in 1984 by exempting medical management of Alzheimer's disease and related disorders from caps imposed on psychotherapy.

The changes made in OBPA raised the dollar limitation that Medicare pays per annum to $1100 (after an effective 50% copayment) over a two year period. Beginning in January of 1989 psychiatrists' outpatient services for "monitoring and changing drug prescriptions" are exempt from the dollar limitations and will be paid at the same 80/20 copayment rate as other physician services. This particular benefit is complicated for beneficiaries and carriers to understand. The proposed regulations and instructions implementing the drug management benefit will hopefully be issued shortly. The passage of these benefit changes was a significant step on the legislative journey toward nor-discrimination and we thank your committee for its fine work in accomplishing this change.

Diagnostic service charges and physician fees in a hospital for patients with mental disorders have always been treated like all other physician services and paid at the 80/20 copayment rate. Unfortunately, despite significant strides in the treatment of mental disorders, patients still are subject to serious discriminatory and arbitrary limits under Medicare in payments for the treatment of their mental disorders.

Treatment in a psychiatric hospital is also constrained to a 190 day limit per a beneficiary's lifetime. These benefits may have reflected treatment patterns in the early 1960's, but do not now reflect current treatment patterns. As you know, expenses incurred for services furnished by other health personnel in conjunction with "or incident to" a physician's treatment of mental, psychoneurotic or personality disorders are not subject to the dollar limits on psychiatrists' treatment services. Thus, additional services may be provided in a variety of settings incident to the psychiatrists' services.

HARVARD RESOURCE-BASED RELATIVE VALUE STUDY (HRBRVS)

Psychiatry participated in the HRBRVS study from its beginning. Our segment of the study was funded by The National Institute of Mental Health (NIMH). APA believes that the approach of the Harvard RBRVS is a thoughtful and useful one. The study's emphasis on supportive, cognitive, assessment, management and caring activities is congruent with our views. Analysis of the preliminary report submitted to HCFA suggested that there were significant problems in the results for psychiatry which were likely to require another survey. The final results of the preliminary report for psychiatry will be submitted to NIMH shortly.

While clearly the Harvard study was an enormous task, expertly undertaken, there are areas which could be strengthened with additional data. On January 17, 1989 the National Institute of Mental Health issued a request for a proposal for a "Refinement of the Development of a Resource-Based Relative value Scale for Psychiatric Services". A contract for this refinement is in the process of being finalized with Harvard.

APA's initial analysis of the Harvard study noted difficulties with the measurement of work; CPT codes for our services; and the measurement of practice costs. Many of these areas of difficulty were also identified by the Harvard researchers and our concerns have also been noted by the PPRC.

Measurement of Work

The APA Work Group identified three problems with the measurement of work that are likely to affect the final RBRVS for psychiatry.

- The vignettes are not representative of practice. Severe cases, such as management of a psychotic or suicidal patient, were not included among the vignettes. In addition, hospital cases often among the most severe patients—are underrepresented. Clinician members of APA's Work Group on the RBRVS believe that some of the vignettes are ambiguous. In fact, Dr. Hsiao found that the degree to which psychiatrists agreed on their ratings of various services was the lowest of all specialties.
- The standard vignette for psychiatry is toward the low end of the scale—only one fifth of the vignettes had ratings of work below the standard.
- Pre- and post-service work measurement has been described by many as a weak component of the RBRVS because values are based on limited data and challengeable assumptions. For psychiatry, there is a particular problem because pre- and post-service time for 11 psychiatry vignettes were set equal to the time for one vignette. Clinician members of the APA work group felt these services, in fact, entailed different amounts of pre- and post-service time.

CPT-4 Codes

Problems with the CPT-4 codes for psychiatry limit the accuracy of the RBRVS values. The two major coding problems affecting the results of the RBRVS are described below along with other coding issues.

- *Mapping Vignettes to CPT Codes*—The mapping process revealed serious problems with the CPT-4 codes for psychiatry. Because psychiatry CPT codes are broadly defined, some codes include vignettes with a wide range of work values. For instance, the total work value for CPT-4 code 90847 (special family psychotherapy) was the average of two vignettes with work values of 186 and 322. APA Work Group members indicated that the vignettes assigned to some codes represented the low end of the range of cases that could be assigned to the codes. It was felt that the vignettes assigned to 90844 (medical psychotherapy) included cases at the low end of the code. This may account for the reduction in value assigned to psychotherapy under the RBRVS, because this is the most common code used by psychiatrists and an error in the work value can significantly skew results.

- *Extrapolation to Non-Surveyed Services*—In order to evaluate the results of the extrapolation, consultants to the APA created a family of "Medical Psychotherapy" that included four surveyed services. In order to test the validity of the methodology, the consultants attempted to determine whether or not the extrapolated values for the other surveyed services approximated the surveyed values. This was not the case, and some extrapolated values appeared to be unreasonable.
- *Other Coding Issues*—Over two years ago, APA established a Work Group on Codes and Reimbursement to address concerns about the inadequacies of the CPT for the wide range of psychiatric services and to prepare an idealized version of potential new codes. Members of this APA Coding Work Group and the RBRVS Work Group recently met together to address some minor modifications which could be made in CPT for psychiatry for the next edition to be published by the AMA. The AMA CPT Advisory Board has indicated a strong interest in addressing changes to psychiatric codes. In addition to problems with the breadth of psychiatric codes—in contrast to the current efforts to reduce codes—psychiatrists have reported ample evidence in certain areas of the country that there are many carriers unwilling to accept general medical codes from psychiatrists. While this is not a uniform experience, enough complaints have arisen to indicate that this is a widespread problem. APA will continue to work with our psychiatrists to assist in this area.

APA staff and psychiatrists also recently met with PPRC staff to discuss coding issues. PPRC staff were also receptive to our concerns.

Practice Costs

APA also noted concerns about the practice cost calculation. Practice costs are, in fact, lower for psychiatry as psychiatrists do not require the same equipment as many other specialties. They may be kept exceptionally low because of three factors: psychiatrists practice in a price-sensitive market resulting from limited insurance coverage of mental health services and high copayments and deductibles; practice costs can represent a consumption good; and many psychiatrists do their own billing and office accounting-costs of office practice not normally included in surveys.

QUALITY ASSURANCE AND PEER REVIEW

As the Committee addresses issues related to volume control, we wanted you to be aware of APA's own peer review and quality assurance program. For over ten years, APA has reviewed claims for the CHAMPUS program and for the past five years has reviewed claims from private insurers. Since 1979, the Peer Review and Quality Assurance Program has reviewed 1.5 million claims for the CHAMPUS program and conducted over 100 on-site CHAMPUS inspections. APA does not deny claims but works with the providers and institutions to assure appropriate provision of care. APA began its work in the peer review area analyzing inpatient cases retrospectively. In 1985, APA became involved with another private group in psychiatric preadmission review and psychiatric case management. The psychiatric case management program combines comprehensive services of preadmission certification and concurrent review of all types of institutional and outpatient care. Information about these programs was given to the Institute of Medicine as it plans its strategy for Peer Review and Quality Assurance under Medicare and was shared with the PPRC.

COMMENTS ON SELECTED RECOMMENDATIONS OF THE PPRC

APA compliments the PPRC and their staff on the extensive amount of work that has been done. Clearly, much thought and effort has gone into their testimony and draft report and the report also attempts to incorporate the important comments of the numerous affected parties. The PPRC's task has been and continues to be an enormous one. Even with the extensive time commitment needed for their report to Congress, PPRC staff have evidenced a tremendous willingness to meet with the APA and expressed verbal support for many of our concerns.

These comments focus only on a limited set of issues. First, as indicated above, Harvard is planning to conduct an NIMH-funded refinement of their study for psychiatry. Because of the expected refinement, psychiatry feels strongly that our portion of an RVS should *not* be implemented until the further analysis has been completed. As noted in our testimony the vignettes chosen for psychiatry did not cover the full range of psychiatric care. Further, given the existing limitations and inadequacies of psychiatry codes under CT-IV, the range of problems treated by psychiatrists cannot presently be appropriately coded. APA is working with both the AMA CPT Advisory Board and the PPRC staff to are fully address these issues and hopefully some coding modifications will be made in the near future. To use the current RBRVS results in Harvard's preliminary report to the NIMH would be clearly inappropriate.

Second, if CPT codes were totally accurate, specialty differentials, as noted in the PPRC draft report, would not be necessary. However, as previously stated and documented, these codes for psychiatry are not adequate. Therefore, the intensity of services provided by psychiatrists are not adequately defined and we feel that specialty differentials *must* be maintained.

Third, implementation of expenditure targets at this point in time would be premature. Without question, there is insufficient information concerning the impact these targets may have on beneficiaries and on service delivery. Unfortunately, and as the Committee and psychiatry know only too well, patients with mental disorders have, since the inception of the Medicare program, been subject to a patient-specific dollar limitation for the majority of their outpatient psychiatric care.

While not similar to a nationwide expenditure target, these patients are already placed at a financial disadvantage and are at continued risk for adequate access to care. Until a demonstration was conducted for national expenditure targets or more information was obtained on the potential impact of such a situation, we feel that our patients must not be placed at additional significant risk.

ADMINISTRATION BUDGETARY PROPOSALS

As you consider some of the Administration budgetary proposals before you, we wish to make a special plea for patients with mental disorders. Some of the services provided to these patients are not primary care services. There should be increases for all services provided by our psychiatrists to patients with mental disorders.

We have shared with the Committee the complicated calculation for the Medicare outpatient psychiatric benefit. In addition, as is well-known, nearly one quarter of psychiatrists' patients have no health insurance. A 1981 study showed that 40% of gross revenues to psychiatrists were on self-pay basis. The distribution of these payments between co-payments and total self-pay is unknown, but it appears that much of the Medicare "balance bill" is in fact a co-payment, because of limited psychiatric coverage and an effective 50% co-payment rate. In addition, because psychiatrists use a small number of codes in most states, and have done so since the 1970's, the Medicare Economic Index may have kept the allowed amount artificially low. Therefore, further limitations may prove to be onerous ones.

Summary

APA supports the concept of an RVS based on resource costs, but feels that implementation of such an RVS for psychiatry must await the planned NIMH-funded refinement by Harvard. Some of the recommendations made by the PPRC may thus be premature (such as expenditure targets). APA's own experience with peer review and quality assurance demonstrates methods of providing cost effective care. We look forward to working with the Committee as these issues are developed further.

STATEMENT OF THE AMERICAN SOCIETY OF ANESTHESIOLOGISTS

Representatives of ASA were active participants in the Harvard/AMA RBRVS study. ASA has serious concerns with the study, but we are supportive of the RBRVS payment methodology and have ourselves published a resource-based relative value guide (RVG) since well before the inception of Medicare.

ASA's comments are tempered by the fact that anesthesiology was not included in either the September final report from Hsiao, nor the Physician Payment Review Commission (PPRC) 1989 Report. Therefore, we do not know what reordering of anesthesia payments may eventually result. Lack of CPT coded anesthesiology claims, inadequate time data, the existence of the ASA RVG, and the unique nature of anesthesia services apparently led to the specialty's non-reported status. We will address these issues, as well as our methodological concerns.

RELATIVE VALUE GUIDE

Anesthesiologists have been reimbursed on the basis of a relative value system since before the enactment of Medicare, and ASA published its first RVG in 1962. ASA has testified in previous years before the Committee on Finance health subcommittee regarding the RVG. We believe the Guide is so important both as the framework for budget reductions and a precursor of the Hsiao/PPRC Resource Based Relative Value Scale (RBRVS), that it is appropriate to highlight its methodology and use.

In its simplest form, the RVG is developed by assigning to each distinct surgical procedure or service a unit value, based on the complexity, effort and resources associated with the procedure. In this way, a table or scale is constructed for a series of procedures or services to which are assigned individual unit values demonstrating the relative complexity of each. These are the base units. For example, in the 1988 ASA RVG, there are 20 base units assigned to cardiac bypass grafts, compared to 4 base units for hernia repairs. Because our Guide and the related CPT-4 codes are broad (there are 250 anesthesia codes for the 6,000 surgical codes), new codes are rarely needed when new technology is introduced. This, in turn, means there are relatively few new services in anesthesiologists' reimbursement.

Time is the essential element in determining the level of anesthesia service for each individual patient and can vary substantially according to each patient's circumstances. Because time is so essential to anesthesia practice, the ASA RVG adds time units; Medicare recognizes one unit per each fifteen minutes of anesthesia time for anesthesiologists providing care directly and one unit per each thirty minutes of anesthesia time for anesthesiologists providing medical direction services.[1]

Anesthesia time is defined as beginning when the anesthesiologist begins to prepare the patient for anesthesia care in the operating room or in an equivalent area, and ending when the anesthesiologist is no longer in personal attendance, that is, when the patient may be safely placed under post-operative supervision.

ASA regards the time factor as enormously important in providing a fair and accurate measurement of the anesthesiologists' services. It is the surgeon, not the anesthesiologist, who controls time. There is a high and stable correlation between surgical time and anesthesia time; operating room and recovery room records yield easy verification of anesthesia time.

I also would like to note that anesthesiologists do not charge beyond the base units for preoperative time spent in evaluating and caring for the patient. Even though complex procedures invariably require a detailed, time-consuming preoperative evaluation, it is still accounted for by the base units.

The ASA RVG also uses physical status modifier units to quantify the medical condition of each patient. The administration of an anesthetic to a patient with severe concomitant systemic disease simply carries a higher risk and requires greater skill than does performing the same procedure on a healthy patient. Research indicates that it is the physical status of the patient, not the surgery or anesthetic, which is the best predictor of surgical outcome.

The RVG, then, describes and measures anesthesia care provided to individual patients. To establish a charge based on the RVG, a dollar conversion factor is applied. Each anesthesiologist has three conversion factors: the Medicare prevailing conversion factor, which is the amount recognized by the carriers for all anesthesiologists in an area; the discounted MAAC conversion factor, which is the individual anesthesiologist's 1984 frozen actual charge with appropriate MEI updates; and the non-discounted conversion factor charged to non-Medicare patients or commercial carriers.

The RVG methodology frequently results in "automatic" savings to the Medicare program. With improved surgical techniques and familiarity with procedures, anesthesia time is often reduced. When this happens, the number of reported time units is also reduced, automatically resulting in a reduction of the total charge, both as recognized by Medicare and to the patient. Similarly, the anesthesia risk and complexity base units may be reduced over time. A prime example of decreased charges resulting from use of the RVG is illustrated by pacemaker implantation. Previously implanted through an open chest requiring two to three hours of anesthesia time, pacemakers are now inserted through a vein in an hour or less. Because of these procedural changes, ASA reduced the base units from 20, to 15, to 4; time units decreased from 12, to 4.

The ASA RVG is not a static document, but one which is reviewed each year and, through ASA House of Delegates' action, changes are approved. The 1988 RVG reduced base units for seven procedures; none were increased. Again, when such revisions reduce base units, there are savings to the Medicare program, commercial carriers, and all patients.

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[1] Prior to implementation of a Part B payment system for certified registered nurse anesthetists (CRNAs) on March 1, 1989, Medicare recognized: one time unit per each 15 minutes of anesthesia time for anesthesiologists medically directing their employee-CRNAs; and one time unit per 30 minutes of anesthesia time for anesthesiologists medically directing hospital-employed CRNAs.

OBRA 87: UNIFORM RVG

Although Medicare has for some years required that anesthesiologists be reimbursed using the RVG methodology, the 54 carriers have not been required to use a specific guide. Section 4048 of the Omnibus Budget Reconciliation Act of 1987 mandated that HCFA establish a uniform RVG for reimbursement of anesthesia services under the Medicare program. Section 4048 was inserted into OBRA 87 at the urging of ASA and was strongly supported by ASA in the course of its consideration by Congress.

ASA clearly supports HCFA's proposed regulation adopting the 1988 ASA RVG and the associated CPT-4 anesthesia codes for services provided after March 1, 1989. We remain opposed to HCFA's proposal to eliminate recognition of physical status modifier units from the uniform RVG recognized by Medicare. Modifiers as measures of individual case severity are an integral part of the ASA RVG; to eliminate them is to adopt an incomplete RVG, one which in essence will distort the measurement of care rendered to many patients.

In light of the Physician Payment Review Commission's support for incorporating severity of illness measurements in the Harvard Resource Based Relative Value Scale, and Dr. Hsiao's indication that the ASA system could be a model, HCFA's proposal does not make sense.

ASA believes a flaw of the RBRVS is that it does not measure or account for severity of illness. A physical status modifier system has proved an excellent way to achieve such a measurement and makes the RVG patient specific.

RESOURCE BASED RELATIVE VALUE SCALE (RBRVS)

The Subcommittee recently heard testimony from both Dr. Hsiao and Dr. Philip Lee, Chairman of the PPRC. PPRC's Annual Report to Congress presents its recommendation that an RBRVS be finalized, with phased-in implementation to begin in 1990. PPRC also recommends increased funding for the development of practice guidelines and standard setting.

With ASA's history of RVG development and the historical use of a relative value system by anesthesiologists, it is not surprising that we are strong supporters of this system. As mentioned, ASA was an active participant in the Hsiao RBRVS study and at the December 1988 AMA House of Delegates' meeting, ASA voted in support of Report AA. While ASA and others will disagree with reductions in reimbursement which could result from the RBRVS, the concept is sound and we believe its adoption likely. Implementation of the RBRVS for all of medicine would bring a dramatic change in physician reimbursement. If the Congress chooses to implement the RBRVS, then, as PPRC has noted, the cooperation of physicians will be required to make it work. ASA believes the American Medical Association must play an important role in the still-needed refinements of the RBRVS and in maintaining physician cooperation. As we seek our specific refinements, we will continue to work with Dr. Hsiao, the AMA, PPRC, and ultimately the Congress.

Certainly, we consider the ASA RVG to be the best existing measurement of anesthesia services, and are gratified that both Dr. Hsiao and PPRC agree. Hsiao indicates he has confidence in ASA's RVG, and its application of base units, time units and physical status modifiers. Indeed, Hsiao states he will "need to translate the RBRVS into the present relative value system used by [anesthesiology] and examine how the RBRVS could be implemented in the context of that existing system." He further states his methodology "is built on one designed by the ASA, which uses time and complexity measures."

Similarly, the Physician Payment Review Commission states in its recently-released report to Congress:

> For anesthesia services, most carriers have long used various versions of the Relative Value Guide developed by the American Society of Anesthesiologists. The RVG bases payment on time, the difficulty of the operation, and patient condition. OBRA 87 directed the Secretary to develop a standard version of the RVG for use by all carriers. The policy has recently been implemented. Since the RVG is clearly resource based and has been in use for some time, the Commission plans to consider it as an alternative to the values developed by the Hsiao study for relative values among anesthesia services. The conversion factor would have to be adjusted to integrate the RVG with the rest of the RVS.

ASA will continue working with PPRC on retention of this accepted methodology within any new system.

Hsiao's RBRVS findings on the limited sampled services shows a high correlation, .96, with ASA's relative value base units and supports "the validity of the ASA approach." Apart from the base unit values, and their relationship to the RBRVS, Hsiao agrees there are special time considerations for anesthesiologists, but lacked the data necessary to extrapolate his study data in this report.

Time is not only a key element of our RVG, but one over which the anesthesiologist has no control. Previous studies related to physician DRGs undertaken by Battelle Human Affairs Research Centers and provided to the PPRC, show a high, consistent correlation between anesthesia time and surgical time (.94) for specific procedures. Ninety-one percent of the variation in time across procedures is predicted by surgical time alone.

ASA is able to compare Hsiao's intra-service time estimates with data from the Battelle study:

Procedure	Hsiao study time		Battelle study time	
	Intra	Other	Surgical	Other
CABG	260.6	113.1	272.9	105.6
Total hip replacement	181.6	86.4	161.2	68.8
Cholecystectomy	99.1	55.8	116.6	36.6
Endarectomy	132.1	68.4	156.4	46.2
TURP	82.2	49.9	65.3	33.0
Inguinal hernia repair	64.5	44.5	70.5	43.1
Open reduction and int fixation hip fx	116.3	62.5	112.2	38.9

Hsiao's pre- and post-service time are often higher than the difference between anesthesia time and surgical time in Battelle. We believe this may be explained by Hsiao's inclusion of pre-surgical anesthesiologist visits. As noted previously, ASA does not "count" this time separately, but considers it part of the base units.

Therefore, notwithstanding the apparent agreement we have with Hsiao's measurement of anesthesiologists' intra-service work and the resulting unit values, the RBRVs by themselves are incomplete and would not be acceptable to ASA without the critical addition of time units.

For example, CPT code 31500, endotracheal intubation, is given an RBRV of 199 for a pediatrician. Does that 199 value mean to imply that the *total anesthetic management* of the patient undergoing a laparoscopic procedure, with an RBRV of 204, is worth only 5 units in addition to the intubation by the anesthesiologist? Obviously we think not, and believe this illustrates why actual time spent must be added to the anesthesiology RBRVs.

ASA believes any relative value system for anesthesia services must recognize actual time spent in any setting. We would support tighter definitions of fractional units, and have so indicated to both HCFA and the Office of Inspector General (OIG).

SPECIALTY LINKS

As we have indicated, Hsiao's measurement of anesthesiologists' intra-service work appears accurate as to intensity, risk and cognitive value. That is, the RBRVS assigned to anesthesia procedures correlate with the base unit values of the ASA RVG. We believe the study falls down and bias enters when Hsiao extrapolates across specialties. It is unlikely that there will be much straightforward translation in the cross-specialty alignment, so it is often a process of "making things fit." The fewer the real intra-service links, the greater the potential for systematic under- or over-valuation of a specialty's services, as the entire alignment hinges on one or two actual links.

The PPRC recognizes that there are significant problems with the Hsiao cross-specialty links for several specialties, including anesthesiology. Other physicians simply do not perform the services provided by anesthesiologists; Hsiao terms anesthesiology an "insular" specialty. ASA does not accept, or even understand, the cross-specialty links for anesthesiology: there are only five links made for anesthesia services, loosely tied together by intra-service time:

Link	Specialty	Service description
1.	an	Insertion of Swan-Ganz catheter
	gs	Insertion of Swan-Ganz catheter
2.	an	Anesthesia for dilation & curettage of uterus
	pe	Office evaluation of head trauma in preschool child with episode of vomiting, established patient

Link	Specialty	Service description
3.	an	Consultation for a transfusion reaction in patient with abrupt onset of fever and back pain
	ai	Medical conference by physician regarding medical management, with patient and/or family; counseling for avoidance, elimination, symptomatic treatment, and immunotherapy
4.	an	Anesthesia for repair of abdominal aortic aneurysm
	ob	Protracted labor requiring pitocin augmentation and electronic monitoring, primigravida, only time spent with patient
5.	an	Anesthesia for caesarean section
	im	Management of patient in acute pulmonary edema in emergency room who subsequently is admitted to hospital, established patient

Only one, insertion of Swan-Ganz catheter, is an actual link—and anesthesiologists often cannot even get reimbursed for this procedure. The transfusion reaction consultation is not common in practice, and would not occur as an independent activity, but would be related to an ongoing procedure.

Perhaps a better example of the failure of cross-specialty alignment is link 5 for anesthesiology. The internist with the pulmonary edema patient is involved with a major interventional procedure and under a great deal of stress in an emergency situation. We do not see how this can be linked to anesthesia for a caesarean section, and would judge the internist to be undervalued in this "link" and the eventual RBRVS.

USE OF AVERAGES

There are also problems associated with using averages, with respect to time or procedure complexity, when constructing an RBRVS. Even under conditions of budget neutrality, the assumption is that on the average, gains and losses, given a large enough number of cases, should offset one another. It is unlikely that there will be case mix differences in kind and number of procedures within and between individual physician practices to allow the winners and losers to offset one another. Hsiao acknowledges this when he states: "Within a specialty, therefore, individual physicians might be differently affected by an RBRVS-based fee schedule, depending on the mix of services they perform."

RBRVS CONCLUSIONS

We must underscore that our comments on the Hsiao study and the PPRC recommendations by necessity reflect a high degree of uncertainty because the anesthesiology simulations have not been completed. We can anticipate that the RBRVS will eventually generate a system of relative values from a small subset of procedures to all anesthesia procedures using the existing ASA RVG. While we are pleased with recognition of our RVG, the major problem with this approach is that it does not incorporate the existing large variation in time within procedures with comparable basic units. Hsiao assumes a constant relationship between time and other factors used to define the amount of physician work involved in a procedure. The appropriateness of the RBRVS for anesthesia services depends on how time and other factors not under the direct control of the anesthesiologist are incorporated into the system.

The existing ASA RVG represents a realistic approach to payment reform since it incorporates units representing the anesthesia complexity of a procedure, the duration of the procedure and patient severity of illness. It is a system which has credibility with payors and researchers, is termed valid by Hsiao and PPRC, and is recognized by HCFA. ASA believes all components of its RVG can be integrated successfully into the Commission RBRVS.

OTHER RECOMMENDATIONS OF THE PPRC

Beneficiary Choice and Balance Billing

The assignment rates for anesthesiologists have increased significantly over the past five years. ASA understands that information (based on an 8-state survey) presented to PPRC by its staff and consultants shows a 70 percent assignment rate for anesthesiologists; other physicians appear to be closer to 80 percent.

One reason for a lower assignment rate is that anesthesiologists receive markedly less "on the dollar" from Medicare than do other specialists. According to data from HCFA and PPRC, the Medicare prevailing charges for anesthesiologists are 40 to 50 percent less than the anesthesiologists' MAAC charges; the reduction rates—that is, the difference between the prevailing and the MAAC—for other specialties do not approach this disparity.

Anesthesiologists do not have access to the same financial information about the patient as does the referring physician. Unfortunately, the discussion of the patient's financial situation frequently comes after the bill has been sent and it becomes apparent that the patient is financially unable to pay. In such a situation, many anesthesiologists will then write-off the patient's bill, but because of the time at which the write-off occurs, the transaction does not appear in the system as an assigned claim.

It makes sense that patients are generally sicker, using more intensive services and accruing greater charges when anesthesia services become a factor. In fact, anesthesiologists' services do not become significant until the patient is in the 95th percentile of Medicare-approved charges per individual. The combination of intensity of service and Medicare reimbursement amounts lagging 40 to 50 percent below charges, account for anesthesia balance bills representing about ten percent of balance bills.

ASA has also indicated to the PPRC and the Congress that we would support an income-related assignment system. This would be an equitable method to assure those in financial need receive consideration, while those able to pay the already-discounted MAC charge would do so.

The argument has been made that anesthesiologists should have special assignment rules because the patient generally does not select the anesthesiologist, i.e., the opportunity to shop for a participating physician is not available. ASA believes this is an extremely weak argument. Patients rarely select beyond their primary care physician; it is the primary care physician who refers patients on to their choice of surgical specialist, cardiologist, oncologist, etc. In many other situations, the choice is made by the hospital, clinic, managed care system, or by a specialist who is already once removed from the primary care physician.

ASA understands that the PPRC Report will indicate that the Commission considered, but rejected, a prohibition on balance billing for select physicians, including anesthesiologists. The PPRC apparently agrees that the definition of limited choice physicians is not clear cut. Further, PPRC would prefer to assess the impact of its recommendation concerning universal limits on balance billing that will be associated with the RBRVS and fee schedule. ASA supports the PPRC's decision not to recommend different treatment for certain specialists.

To target anesthesiologists as radically different—as to assignment rates, balance bill liability or lack of patient choice—appears without foundation.

In past years, this subcommittee has recognized that anesthesiologists are not in a position to influence volume. However, there is a related issue with which we have dealt: if we cannot control the number of anesthesiology services being provided, we can address the quality and performance of each service. In other words, we can seek to assure that anesthesiologists provide the services that are being reimbursed.

ASA was the first specialty to set national standards and has adopted four to date: Basic Standards for Preanesthesia Care; Standards for Basic Intra-Operative Monitoring; Standards for Postanesthesia Care; and Standards for Conduction Anesthesia in Obstetrics. The most important role of standards is to improve patient safety, but they also can tell the patient and insurer that they have received what they paid for.

Regarding several of the other specific recommendations contained in the PPRC Report, ASA makes the following comments:

- Recommendation: Premiums for liability insurance should be integrated into the RVS through a separate practice cost factor. The medical liability crisis continues to be out of control. Anesthesiologists have gained some relief in premiums due to the standards set by ASA and other risk management initiatives. ASA supports the intent of PPRC's recommendation: (1) separate consideration of the liability factor will help show the unacceptable costs; and (2) there will be consideration of both geographic and practice differences.
- Recommendation: Fee schedule payments should vary geographically. ASA supports valid geographic cost of practice variations.
- Recommendation: A uniform policy on the delineation of carrier charge localities is needed. Carrier variations, both as to coverage decisions and payment rates, follow no clear pattern. Any improvement of the charge area boundaries would be a step toward uniformity in the program.
- Recommendation: A transitional stage should begin in 1990, with implementation of the full Medicare Fee Schedule planned for 1992. Although ASA is pleased that its RVG is being considered as an alternative to development of new values, the specialty of anesthesiology has not been fully considered by either Hsiao or

PPRC. Without knowing the outcome, ASA cannot support a 1990 implementation of the RBRVS, and suggests 1991 as a more reasonable date. Considering the overwhelming changes the RBRVS will bring to all of medicine, we believe it is worth taking the time to do it correctly.

ASA further strongly recommends at least a three-year transition period to the fee schedule. The disruption to physicians and patients of a relatively abrupt transition would undermine the reforms and discourage the needed physician cooperation.

- Recommendation: A national expenditure target should be used to determine annual conversion factor updates under the fee schedule. ASA has two comments with regard to expenditure targets. First, within the context of the PPRC report, we must say that until the RVS conversion factors are known, it is difficult to assess the impact of expenditure targets. Further, the concept of seeking to exert peer pressure among 500,000 physicians to meet a national target is an unrealistic approach to controlling volume.

Statement of the American Society of Cataract and Refractive Surgery

SUBMITTED BY STEPHEN A. OBSTBAUM, ASCRS PRESIDENT

Dear Mr. Chairman: The American Society of Cataract and Refractive Surgery (ASCRS) is pleased to have the opportunity to comment on the Harvard Resource-Based Relative Value Scale (RBRVS) and the role this study should play in physician payment reform under Medicare. As a practicing ophthalmologist from New York, I had the opportunity to participate in the Harvard Study as a member of the technical panel during the development of the study. I expressed concern about aspects of the methods used for data collection and interpretation of data into the study. Throughout the study development process, at least in the ophthalmology technical panel, we were closely controlled and specifically directed to smaller and more limited tasks, such as reviewing the adequacy of descriptions of vignettes; rarely was the opportunity provided for broader and more meaningful participation in the study by those of use who represent physicians most affected by it.

Others have pointed out specific concerns that the Cataract Society shares regarding methodology of the Harvard RBRVS. Perhaps foremost for us is that the study's analyses of time and intensity for the procedure itself, as well as in the preoperative and postoperative periods, were most inadequate, causing serious distortion. Cataract surgery with intraocular lens implantation can be a relatively brief surgical procedure itself when only "skin-to-skin" time is compared with that of major surgery in some other specialties; but cataract/IOL surgery is extraordinarily delicate and intense.

The complexity and intricacy of this microsurgical procedure is predicated upon the diagnosis, evaluation, and patient preparation. Postoperative management requires appropriate attention to detail and is arduous, intensive period.

Ophthalmologists must apply their highest skills and best judgment to achieve patients' optimum visual results. In the Harvard RBRVS, the value of surgical time and intensity, as well as the time and intensity of preoperative and postoperative services, are measured using a series of arbitrary estimates which we believe greatly minimize the value of time and intensity in cataract/IOL surgery. We also have concerns about methodologies used for extrapolating the value of non-surveyed services within specialities and for cross-linking the value of services among specialties. We believe these factors all contribute to the inaccurate results in ophthalmology.

We are concerned about the techniques applied in the Harvard RBRVS to measure practice costs. The base data used in the study dates from 1983. Since that time, many of the practice costs in cataract and intraocular lens implantation surgery have increased more rapidly than increases in other specialties, while reductions in reimbursement are not reflected. Ophthalmologists typically maintain expensive equipment within their offices for the examination, diagnosis, and treatment of conditions of the eye. Each year our specialty becomes more dependent upon new technology and attendant equipment.

The accurate and objective measurement of practice costs, as recognized by the Commission and Dr. Hsaio, is of prime concern in any relative value scale. Based on a 1985 Cataract Society membership survey, it was determined that average practice overhead was 48.7%. Through a more recent telephone survey, it was learned that start-up costs could reach $225,000, with basic equipment purchases represented by a range of $100,000 to $120,000.

We must again reiterate the strong concern of the Cataract Society that measurements of the value of medical procedures or services which rely exclusively on input costs lack other essential factors. An assessment of the value of a medical procedure or service, whether made by the patient or the reimburser, must also include such factors as the patient's outcome, quality of care, benefit to the patients, benefits to society, and market forces. Dr. Hsaio himself has stated, in summarizing the Harvard RBRVS in the New England Journal of Medicine the following:

> "The RBRVS measures only inputs . . . A rational payment should recognize social benefits in the relative value. Perhaps this topic should have a high priority in future research." Mitchell, Stason have likewise stated: "Resource costs, even if accurately calculated, are incomplete measures of the value of physicians' services. Expected health benefits to the patient also need to be included in the definition of relative values."

Cataract surgery and intraocular lens implantation has evolved as a procedure that is safe and effective, providing benefits to patients, their families, and indeed all of society to an extraordinary degree. As members of the subcommittee may know, cataract and IOL surgery has been found previously to be "over-priced", we believe this operation to be "under-valued" when all reasonable factors of value are considered.

To examine this more closely, the Cataract Society, along with others in ophthalmology, has commissioned researchers at Johns Hopkins University to undertake a scientific study of patient benefits from cataract/IOL surgery. The premise of the study is that noneconomic variables should be central to medical decisions. The Johns Hopkins study measures the effects of cataract surgery with intraocular lens implantation on patients' future functioning and "quality of life". The design includes both pre-surgical and post-surgical measurements after one month and 8½ months. A statistically valid sample of some 1,000 geographically-dispersed patients has been objectively surveyed for changes in mental health, physical and social activities, independence, and accident prevention.

The study quantified patient benefits from cataract/IOL surgery using methodologies adaptable to any medical procedure or service. Beyond the importance of this study in cataract surgery itself, we believe it will demonstrate that patient benefits from a medical procedure or service *can* be measure accurately. If so, the Cataract Society strongly urges the subcommittee to recommend that the Harvard RBRVS study results be supplemented and adjusted to account for the patient benefit factor in all medical procedures and services.

Preliminary descriptive materials on the Johns Hopkins work are available and will be delivered to members of the subcommittee under separate cover.

The Cataract Society is interested in the subject of "balance billing". Since 1984, physicians have been limited in what they can charge Medicare patients for their services, beyond the amounts established by Medicare. Balance billing limits raise serious problems which increase with the longevity of those limits. The limitations effect a federal price control system, which inevitably distorts supply, inhibits innovation, and invites way to "beat the system". The controls encourage treatment practices that reflect the limited reimbursement. No responsible physician is likely to make changes that risk a patient's result; however, many aspects of health care must change if competitive pricing is prohibited, such as consultation time, availability of equipment, satellite office, paraprofessional assistants, clinical research, and billing assistance.

Balance billing limits, if they persist, create the risk that there will one day be two classes of patients, "private patients" and "government patients." The Cataract Society urges the Senate Finance Subcommittee on Medicare and Long Term Care to recommend that balance billing limits be lifted.

Once again, we are most appreciative of this opportunity to respond and we very much look forward to further discussion in the near future.

STATEMENT OF THE AMERICAN SOCIETY OF INTERNAL MEDICINE

The American Society of Internal Medicine (ASIM) appreciates the opportunity to present its preliminary evaluation of several of the recommendations made by the Physician Payment Review Commission (PPRC) on reform of the existing system of reimbursement under Medicare. Given the fact the we have not yet had the opportunity to review the Commission's annual report to Congress, this statement should be reviewed as a *preliminary* evaluation based upon initial reports on the Commission's likely recommendations, rather than a conclusive statement of policy. We expect to provide Congress with an expanded and more complete statement once we have had an opportunity to review the Commission's written recommendations.

IMPLEMENTATION OF A FEE SCHEDULE BASED ON THE RBRVS

The Commission is expected to recommend that Congress mandate implementation of a fee schedule based on the Harvard Resource Based Relative Value Scale (RBRVS) beginning on April 1, 1990, and phased in over a two year period with the new payment rates taking full effect on April 1, 1992.

ASIM strongly supports this recommendation. The Harvard RBRVS, as refined by the Commission, is the product of more than ten years of debate, research, and analysis. It reflects the desire of Congress, as reflected in the Omnibus Budget Reconciliation Acts of 1985, 1986 and 1987, to correct distortions in the existing pricing system that favor high cost technological services over evaluation and management (otherwise known as cognitive) services. Timely implementation of a fee schedule based on the RBRVS offers significant advantages for payors and beneficiaries, including:

- *It will correct existing incentives that may adversely affect the volume of services provided to Medicare beneficiaries.* By no longer paying physicians disproportionately higher for the work involved in invasive procedures compared to evaluation and management services, physicians no longer will have an incentive to substitute expensive technological procedures for cost-effective evaluation and management services. As such, the RBRVS is an important step toward ensuring that medical decisions are based solely on what is best for the patient, not on which service or procedure is the most financially rewarding. Although a fee schedule based on the RBRVS will not by itself completely solve the "volume" problem, it is an essential part of a comprehensive strategy to assuring that only effective and appropriate services are provided to Medicare patients.
- *Physicians will no longer be penalized for spending time with patients.* Public opinion surveys show that patients' number one complaint about physicians is that they do not spend an adequate amount of time with them. The RBRVS, by paying more appropriately for the time spent in providing evaluate and management services, will make it possible for physicians to spend significantly more time with their patients.
- *It will simplify the Medicare program.* Beneficiaries will be able to anticipate in advance how much Medicare will pay for a given service, and thereby better understand their potential out-of-pocket liability. An RBRVS fee schedule will also facilitate competitive pricing for physician services.
- *It will improve access to primary care services, particularly in rural areas.* By paying better for evaluation and management services, and by correcting geographic inequities, physicians will have an incentive to enter primary care specialties and to practice in underserved areas.

On other issues relating to the Commission's recommendations on an RBRVS fee schedule, ASIM:

- Supports incorporating average time descriptors in CPT-4 codes for visit services.
- Supports establishing the initial dollar conversion factor at a budget neutral level.
- Supports limiting variations in payment levels by region only to actual differences in the cost of providing services (overhead). This will significantly improve access to physician services in underserved rural and inner city communities.
- Supports the concept of establishing an appropriate "safety net" to protect low-income beneficiaries from excessively high out-of-pocket expenses. ASIM strongly believes, however, that it is inappropriate and unnecessary to establish an overall limit on charges to all beneficiaries at some percentile level above the payment levels established by the fee schedule. Such a requirement, in ASIM's view, is a prescription for mediocrity. In every field, whether talking about an engineer, attorney, architect, or accountant, there are some individuals that have more experience, greater expertise, and offer a better service than the norm for their field. Those individuals typically and appropriately charge bore for their services than the average. This is as true in medicine as it is in any other field of endeavor. Patients should have the right to select physicians who bring greater skill to treating their individual problems, and who therefore have an appropriately higher charge. Limiting all physician fees to some pre-determined percentile above the RBRVS fee schedule would preclude that choice. It would also act as an discentive for physicians to obtain additional skills and training, since there would be no additional compensation to recoup the cost of such training. Any fee schedule, even one based on resource costs, by its nature represents a standard or average; balance billing is the only way to recognize differences in the skill and training of individual physicians, and in the needs and desires of individual patients.

Consequently, *ASIM strongly urges Congress to move expeditiously on mandating implementation of a fee schedule based on the RBRVS, as recommended by the Physician Payment Review Commission, beginning on April, 1990.* The new schedule would be fully in place by April 1, 1992. We also support appropriate measures to protect low-income beneficiaries from high out-of-pocket expenses, but urge Congress to reject the Commission's recommendation to establish an overall limit on charges to all beneficiaries.

EXPENDITURE TARGETS

ASIM is surprised and disappointed that tne Commission reportedly will recommend the establishment of a national expenditure target, taking into account estimated increases in price, volume, and number of beneficiaries, beginning on January 1, 1990. Although details of this proposal have not yet been provided, spending on physician services that exceeds the expenditure target would lower future increases in payment levels (i.e., the conversion factor under the RBRVS fee schedule) in order to offset those higher spending levels. It is unclear at what level the expenditure target will be set, although presumably it will be established at a level that is below the estimated increase under current law in overall expenditures (price times volume of services).

We believe that this recommendation should not be accepted by Congress for at least the following reasons:

- *Unlike the recommendation on the RBRVS fee schedule, which reflects over ten years of debate and evaluation, and three years of intensive work on the part of the Commission, the expenditure target concept has not undergone critical scrutiny.* This concept has not been the primary focus of the Commission's hearings and work over the past several years. Consequently, the Commission has not had the benefit of the same type and degree of expert advice, public comment, and research that were reflected in its recommendation on the RBRVS fee schedule. This is unfortunate, particularly given the fact that the expenditure target approach could have even greater ramifications for the quality and accessibility of medical care in this country than a fee schedule.

- *The purpose of the expenditure target approach is to limit services provided to Medicare beneficiaries. As such, it is a form of rationing.* According to the dictionary, "ration" means to restrict to limited amounts. The Commission acknowledged in its March 1988 report to Congress that "the intent of expenditure targets is to make explicit to physicians the limits of the resources society has decided to make available for health care . . ."

Presumably, the Commission intends for only "unnecessary" or "ineffective" services to be eliminated. Given the lack of data and consensus on the effectiveness of different medical services and procedures—and the inherent contradiction in attempting to set a limit on overall expenditures without any public consensus of how much should be spent on medical care—it takes a large and unjustified leap of faith to presume that only "waste" will be cut from the system.

Put into individual terms, expenditure targets can only work if individual doctors decline to provide certain services to their patients that they otherwise would have provided. *Without a scientific basis for making such a determination, however, it is just as likely that "effective" as "ineffective" services will be denied, particularly in grey areas where there is no clear consensus on what is the best way of treating a particular problem.* Consequently, it is the patient, not the physician, that is at risk under the expenditure target concept. This distorts the physician's traditional role as advocate of his or her patient, by placing the physician in the position of limiting services to patients in order to meet predetermined targets established by the federal government.

- *It is unclear how the medical profession can collectively control utilization across the country in order to meet the expenditure target.* An individual physician who practices a conservative style of medicine would still be financially penalized if overall expenditures exceed the expenditure target limit. Similarly, lower cost regions of the country will be at risk for higher utilization in other parts of the nation. Physicians in one specialty will similarly be at risk if physicians in other specialties increase their volume of services. Consequently, expenditure targets place individual physicians at risk for behavior by their colleagues that is outside their own control. Moreover, there is no organized system of utilization review now in place nationwide that would enable the profession to collective control the volume of services.

What is needed instead is the development of the data and scientific basis needed to establish guidelines for evaluating the effectiveness of different medical and surgical interventions. ASIM recently released a 14-point plan for controlling the volume of ineffective services. Copies are available from ASIM. A strategy designed to obtain the knowledge—and the means—for reviewing and evaluating the effectiveness of different ways of treating patients offers far more potential than expenditure targets for *appropriately* controlling the volume of ineffective medical services, without compromising patient care. By developing guidelines first for high volume procedures where it may be relatively easier to obtain a consensus on effectiveness, it is likely that the Medicare program can begin saving significant amounts of money in the relatively near future—without resorting to the imposition of expenditure targets.

For these reasons, ASIM urges Congress to act cautiously before rushing into a decision on national expenditure targets. A cautious approach to making a decision on expenditure targets, however, should not preclude an early decision on implementation of an RBRVS fee schedule. Reform of the pricing system needs to be done regardless of what approach to the volume problem is ultimately decided upon by Congress. Moreover, unlike the expenditure target concept, the RBRVS fee schedule has a far longer track record of public debate, research, and evaluation that will enable Congress to make an informed decision *now* on the desirability of this policy recommendation. Therefore, it makes no sense to hold the decision on the RBRVS fee schedule hostage to making a final judgment on expenditure targets and alternative approaches to controlling volume.

STATEMENT OF THE AMERICAN UROLOGICAL ASSOCIATION

The American Urological Association (AUA) is the national medical specialty society representing nearly 5,000 of the nation's urologists engaged in teaching, research and clinical practice. Urology was one of the eighteen medical specialties reviewed by William Hsiao, Ph.D. and his research team at Harvard University in their development of a resource based relative value scale (RB-RVS). AUA has worked closely with the Physician Payment Review Commission (PPRC) on several aspects of a new Medicare fee schedule and welcomes the opportunity to comment on the Commission's proposals.

RECOMMENDATIONS OF THE PHYSICIAN PAYMENT REVIEW COMMISSION

PPRC has spent much time working on their 1989 report and AUA has been an active participant. We applaud the openness of their process and the excellence of their staff. While AUA does not always agree with their conclusions, we recognize that PPRC has tried hard to resolve some difficult issues and has been open to opposing views.

AUA is, however, very concerned that there may be a rush to judgment in favor of PPRC's new fee schedule without an adequate opportunity to complete the kinds of work that PPRC recommends and without adequate testing of the concepts in the real world. The report is filled with recommendations for additional studies and refinements. Major issues still need to be resolved. AUA urges Congress to allow those efforts to go forward before deciding on the utility of this particular method of determining Medicare payments to physicians. For example, it appears that eight of the eighteen medical specialties reviewed for the Hsiao study are being reanalyzed in one fashion or another. That fact should argue strongly for delay in adopting the new fee schedule. AUA is now examining material recently published material by Hsiao to see if urology also needs to be re-examined.

Medicare now operates with an individual fee schedule for every physician, based on individual charge histories. PPRC proposes moving from this highly individualistic set of fee schedules to a national one. The primary basis would be resource costs as opposed to charges. Congress must decide whether moving to this national fee schedule is appropriate and would lead to program improvements. However, a new fee schedule is just as likely to introduce problems into the payment system as did the current process. AUA acknowledges that the way Medicare payment is now determined is not perfect; however, it is naive to assume that a new system, whatever its basis, would not introduce its own distortions. With that in mind, AUA urges great caution in the Congressional consideration of these proposals to dramatically alter the current system.

AUA questions whether or not resource costs should be the only or even the primary basis for determining Medicare payment. Even conceding that there are some inappropriate disparities in the payment for different kinds of services, the science of analyzing resource costs is so new that we have little confidence that such a system will improve the current situation to any great degree.

PPRC has accepted as the basis for the RVS the initial estimates of physician time and effort developed by Dr. Hsiao at Harvard. PPRC acknowledges that much work still needs to be done to refine that methodology. That is why we believe Congress should defer action on a fee schedule based on resource costs until the further analytical work has been completed. Significant questions remain about the pre- and post-work measurements, the quality of the vignettes, the way in which physicians responded to the questionnaires, the extrapolations to non-surveyed procedures and other technical aspects of the study. The results are very important to Medicare patients, physicians and the government. It is essential that the work be completed properly before the conversion to a new system is made.

We agree with the Commission that any fee schedule should incorporate practice costs calculated separately. However, AUA would be concerned if the use of an index averages costs in such a way that many physicians will not recoup their real costs of practice because they don't meet some "average" definition. Practice costs might have to be figured more on an individual basis in order that physicians be treated fairly in all parts of the country. The cost of living, as well as the cost of practice, may need to be examined in order to assure payment equity among physicians. Some payments in certain geographic areas are badly in need of upward adjustment; however, cost of living differences are real and cannot be ignored. To suggest, as does PPRC, that surgeons in large cities could have their Medicare income reduced by 25% is not appropriate. Such a conclusion totally disregards the realities of living and working in those areas. Other professions may adjust their fees to reflect cost-of-living. Why should physicians be singled out for this unfair treatment?

We are disappointed that the Commission does not want to include a factor for additional specialty training because we think that specialized training is an important component of the service that the patient receives. We do not believe that simply because two different kinds of physicians, one specialized and one not, use the same CPT code means the patient has received the same service. We believe that there are efficiencies, economies and intensities that a specialized physician brings to a service that should be accommodated in any payment structure.

The AUA is working with PPRC on the definitions for evaluation and management services, as well as on the global surgery package. We believe that PPRC has done some excellent work in this area. Because work on these definitions is not finished, it is very difficult to make comparisons between evaluation and management services and surgery. Therefore, we think those comparisons should await a standardized set of definitions, which is the object of this effort. Until everyone is speaking the same language, comparisons will have little meaning.

PPRC has recommended that there be a limit on balance billing on all unassigned claims. The American Urological Association objects to that proposal, preferring that the balance billing limits be associated with the income levels of beneficiaries. AUA believe that mandatory assignment should apply to low income Medicare beneficiaries. On the other hand, we see no reason why physicians, non-Medicare patients and taxpayers should have to subsidize the cost of medical care for those Medicare beneficiaries who are perfectly capable of paying the charges in full.

PPRC cites the need to monitor the impact of the new fee schedule if its recommendations are adopted by Congress. This suggests a degree of uncertainty about the proposals which we find very troublesome. AUA believes it would be better for Congress to subject the recommendations to demonstration projects to see if they work as intended. We believe that many of the impacts of such a system can not fully be appreciated in advance, regardless of the skill of the simulators; therefore, we urge demonstration projects before adoption of this or any other new national fee schedule.

The most controversial part of the PPRC recommendations is the national expenditure target for physician services. While we recognize the difficulty of dealing with the current budget situation, we do not believe that an arbitrary expenditure cap or budget ceiling or target is appropriate. AUA thinks it will lead to rationing of care over time, much as has happened in the Medicaid program in many states. In those nations where budget targets have been implemented, patients have experienced long waiting lines or denial of care. We do not believe that is an acceptable trade-off for the American public. We believe that Congress should reject the recommendation for a national expenditure target for physician services. It is too simplistic an approach to this extremely complex problem.

An alternative to a target to control growth in volume is the use of guidelines or standards for medical care. We urge Congress to work now with the physician community to develop standards of medical care. There is no question that medical uncertainty causes some inappropriate utilization. To the degree the physician community can reach a consensus, inappropriate utilization can be reduced. We think that medically derived standards of care are a far better approach to dealing with program growth than arbitrary budget targets.

As part of the development of these guidelines, we urge Congress to create an environment in which physician organizations feel free to develop and publicize these standards. Many physician organizations are now concerned that they will run afoul of the Federal Trade Commission or the Anti-trust Division of the Justice Department if they pursue these activities. We believe that Congress should create a climate in which the physician community can work with other public interests to develop effective standards of care that will curb inappropriate utilization. The absence of this climate will slow the development of these guidelines and certainly reduce the appropriate medical input.

Medical care is sufficiently complex to require that the specialists who perform services be the ones most involved in the development of standards of care. It simply cannot be done by those who are unfamiliar with the particular services in question. Do not assume that all physicians know all things about all medical practice. This means that AUA and urologists should develop the standards for urologic care. Other specialists should examine their own fields. These standards should then be carefully reviewed by other interests before adoption as part of the overall payment mechanism.

Part of this activity should be a strengthened research effort examining the effectiveness of various medical practices. This program should look at areas where medical uncertainty exists and try to help physicians resolve that uncertainty. We are encouraged that Congress is moving in this area.

Finally, we concur that PPRC is on the right track when it recommends some limits to the kinds of incentive plans that should be used in health maintenance organizations and other prepaid settings. We do not object to all incentive programs designed to encourage appropriate use; however, we believe that those which put the referring physician at great financial risk can lead to inappropriately low utilization of services. We believe that Congress should heed the recommendation of PPRC in this regard.

IS TURP "OVER-VALUED"?

A major concern AUA has with the preliminary results of the PPRC's work is the suggestion that transurethral resection of the prostate (TURP) is overvalued by Medicare by some 18%. A reduction in Medicare payment for TURP of that magnitude would have a significant impact on urologists.

In 1987 Congress reduced payment for a number of surgical and diagnostic procedures, including TURP. AUA argued at the time that TURP was not over-valued. We felt that the only reason for including TURP was the fact that it is the second most common surgical procedure under Medicare. In the absence of an alternative to care for prostatic enlargement and its symptoms, TURP will continue to be a high volume Medicare procedure because the condition that it successfully treats is one that occurs commonly among older men.

TURP is now going to be subject to pre-admission review by PROs throughout the Medicare program. If the 1987 volume of 255,471 procedures is inappropriate, this intensive PRO review will reduce it.

Since 1987, more data on TURP has become available. An independent, nationwide study of urology practice completed in late 1987 is the source of this new information about TURP and other aspects of urologic care. Based on that information, we reaffirm our belief that TURP is not "overvalued" by Medicare and we dispute the conclusions of PPRC.

There are several reasons why AUA feels that TURP is not "over-valued". First, the 1987 survey of practicing urologists asked them to rate a series of urologic procedures according to their relative value. The survey sample was over 20 times larger than the one used by William Hsiao and the Harvard research team to develop its relative values for urology. The large sample of urologists put TURP at a higher level of relative value than had Dr. Hsiao in either his 1985 or his 1988 analysis.

AUA has also seen a variety of views on the relative value of TURP. Since 1986 it has been suggested that TURP is overvalued by 40%, 18%, and 36%; that its relative value is close to the Medicare charge level; and that it may be under-valued slightly.

The point of all of this is not to say that the AUA survey was right or that Dr. Hsiao was wrong, but to demonstrate that determining relative value is not easy. This is amply demonstrated by the variation in the results of the different analysis.

Our concern over the limits of this analysis are shared by others. For example, we cite the Physician Payment Review Commission's draft report. In Chapter II-1, on page 2, PPRC notes "the data from those specialties already studied in phase 1 must be reanalyzed and in some cases individual specialties restudied with the improved methodology." The recognized need for these improvements argues strongly that Congress should be cautious in adopting PPRC's recommendations or using them for budget decisions.

Another reason why TURP should not be considered an "overvalued procedure" is found in Dr. Hsiao's own work. When he published his initial results in October 1988, he wrote an article in the Journal of the American Medical Association of October 28 (Volume 260, No. 16) looking at the potential effects of a resource based relative value scale (RB-RVS). On pages 2431 and 2432 he included a table (table 2) which compared 1986 Medicare mean charges (mean submitted charges in 1986) with the RBRVs for the services of many medical specialties, including urology. He concluded that the relative value for TURP was 1,433 and the 1986 Medicare mean charge was $1,412. Dr. Hsiao then noted the following: "Table 2 presents the RBRVs for four selected services in 18 specialties and compares them with 1986 mean charges submitted to Medicare. These data are presented to enable physicians and reimbursement experts to assess for themselves the reasonableness of the RBRVs and to see how they differ from the current charges."

Dr. Hsiao further notes in the same article "as Table 2 shows, the ratios of Medicare charges to RBRVs vary widely, from 0.16 to 1.62. In other words, current charges do not consistently reflect the resource cost of services." However the resource cost of a TURP was extremely close to the current charges. Can we then conclude that current charges for TURP "consistently reflect the resource cost of services"? If so, how can it be argued that TURP is over-valued by Medicare? It is only by applying a "budget neutral" control to the analysis that Dr. Hsiao and PPRC concluded that TURP is overvalued (by very different amounts).

Another reason why AUA feels that TURP should not be considered overvalued by Congress is that the comparison of Medicare charges and relative values is generally a comparison of apples and oranges. That is, the Medicare payment reflects the bundle of surgical services—all the things both before and after the operation, both in and out of the hospital, that the surgeon includes in the fee to the patient. From the 1987 study of urology, AUA has a good understanding of the surgical bundle for TURP. Thus we know that the Medicare payment reflects a number of individual services and visits. The measurement of TURP by Dr. Hsiao and PPRC does not reflect all of those inputs. In fact, PPRC is working on a model definition of the surgical bundle for all surgery to insure that meaningful comparisons can be made. That work is not complete. What this means is that these relative values measure only part of the surgical bundle, whereas the payment measures the whole bundle. Until such time as PPRC completes its work on the surgical bundle definition, including one for TURP, AUA thinks that these kinds of comparisons are inappropriate and inadequate, and should not be the basis for policy or budget decisions.

Finally, AUA has compared what Medicare pays for TURP to payments by other third party payors. In almost every case the Medicare payment is less than private pay. The average difference is twenty percent. This does not appear to us as if Medicare "overvalues" TURP when compared to other payors.

IMPACT OF TURP PAYMENT CHANGE ON UROLOGIC CARE

There is another consideration specific to urology which the Committee needs to look at very carefully. TURP is a major surgical procedure for urologists. It makes up a large part of their surgical case load and is an important source of revenue for the physician. Urology is a narrow specialty. That is, there are relatively few procedures and services that urologists provide to patients when compared to other medical specialties. If payment for one procedure is cut in another, broader specialty, those surgeons may be able to absorb that cut more easily and minimize some of the impact. The urologist, on the other hand, does not have the breadth of procedures and the dislocation can be magnified.

A recent study of Connecticut Medicare claims data for 1986 indicates that Medicare payment for TURP is 36% of the total Medicare revenue for urologists in that state. The 1987 study of urologists nationwide demonstrated similar levels of revenue from this procedure. That means that the degree of dependence on TURP is high and changes in payment are keenly felt. This reinforces the fact that a substantial reduction in payment for TURP would have a disproportionate impact on urology.

The chief concern of Congress for the Medicare program must be to assure that program beneficiaries continue to have access to important health care services. Over the last decade, the number of urologists around the country has increased. This is fully documented in manpower studies conducted by AUA in 1975 and 1985.

The impact of this growth is an increase in the ratio of urologists to population and a dispersion of urologists out of metropolitan areas and tertiary care centers into smaller communities and their hospitals. What this means for Medicare patients is that urologic services are more readily available close to home than they once were.

However, continued erosion of Medicare payment could have the effect of erasing these gains in the distribution of urologic care. Often payments are already lower in those non-metropolitan areas and further cuts could be very disruptive.

For example, in the states of Kansas, West Virginia, Minnesota and Texas there was a substantial increase in the availability of urologic services between 1975 and 1985. Even so, according to AUA's 1985 study, in Kansas 82 of 105 counties had no resident urologist and another 17 counties were served by no more than two urologists. In West Virginia, 34 of 55 counties have no resident urologist and nearly 30% of those in practice today are over 55, thus nearing retirement. If these physicians retire or leave, patients will need to travel farther to receive urologic are. At best this is an inconvenience to patients and their families. At worst, it could be dangerous.

In Minnesota, thirty seven percent of the practicing urologists in 1985 were over 55. Retirement of this many physicians would significantly affect the availability of urologic services in that state.

Texas perhaps showed a more dramatic picture. In 1985, nearly 40 percent of all urologists in the state were over 55. Of four urologists in Anderson County, only one was under 60. The youngest urologist in Angelina County was 54. Many other Texas counties were similarly situated or else had no urologists in them (203 of 254 counties). Patients in these counties can and do travel to get services. Some may not be inconvenienced; others may be.

Once available only in relatively populous areas, urologists have moved to other communities and are meeting medical needs there. However, if the income stream is not available to sustain a practice, these physicians may be inclined to leave these smaller communities and rural areas in favor of better paying metropolitan areas. Some physicians may decide to retire since they feel that the efforts of medical practice are no longer worth the income to be derived from it. If they do, it may be very difficult to replace them with competent urologists because payment in the rural areas is low. Since payment in rural areas and small towns is already below that of the cities, to erode that further only makes it more difficult for these communities to sustain this medical care.

Now it might be argued that many of these services can be provided by other physicians, but such a result would not be consistent with good or economic medical care. A surgeon not trained in urology is likely to have little experience with TURP and would probably choose an open prostatectomy if called upon to deal with an enlarged prostate. That is an easier operation for a surgeon to perform, but it has a minimum hospital stay of eight to nine days and a much longer recovery period for the patient than does TURP. A TURP has a hospital stay of 3 to 4 days, a reduced mortality and morbidity rate, and a faster recovery time. The TURP is thus the more economical and efficient procedure not only for the patient, but also for the Federal government (the physician's fee for both procedures is about the same). Thus it is more efficient to have urologic services available to these patients than to not have them available. Certainly from the point of view of the patient, it is better to be closer to home and family during the surgery and follow-up care.

It is extremely important that as Congress evaluates budget options, it look closely at the impact these policies may have on the delivery of health services in small communities and rural areas. Already the rural hospitals are concerned about the impact of DRGs. We urge you to be similarly cognizant of rural physicians of all specialties. Remember that Medicare beneficiaries need not only primary care, but also other kinds of specialized medical care. This is dictated in large part because of the chronic illnesses that frequently afflict older people and require specialized attention and intervention.

In conclusion, AUA congratulates the Physician Payment Review Commission and its staff for the extensiveness of its analysis and the willingness of the Commission to try to accommodate many important needs and concerns. We believe, as PPRC apparently does, that a great deal more work needs to be done on the design of a new fee schedule for Medicare. We hope that you will also recognize that need and allow more work to go forward before you act to put a program in place.

We disagree with PPRC that resource costs should be the primary means of determining payments. We think that other factors need to be incorporated and that through a balancing of these inputs a variety of diverse goals can be achieved. We believe strongly that the patients who are served by the Medicare program should continue to have access to the full array of medical services that are available to anyone else in the United States. Congress should not take steps now that may make the Medicare patient a second class citizen when it comes to medical care. That would be a tremendous disservice to the patients who rely upon this program.

STATEMENT OF THE COLLEGE OF AMERICAN PATHOLOGISTS

The college of American pathologists appreciates the opportunity to comment on the 1989 recommendations of the Physician Payment Review Commission and on the budget proposal to eliminate an increase In the Medicare Economic Index (MEI) update for nonprimary care services in fiscal year 1990. The College represents more than 10,500 physicians who are board-certified in pathology. Our members provide patient care services in hospitals and independent laboratories.

PHYSICIAN PAYMENT REVIEW COMMISSION (PPRC) RECOMMENDATIONS

The College commends the Commission on its work and supports some of the proposals made by the Commission. Other recommendations are premature or unwise in our view. We strongly advise against adopting all of the PPRC recommendations. We submit the following specific comments on the 1989 recommendations of the Commission:

1. The College *strongly advises against including pathology services in RBRVs implementation until the Hsiao restudy of our services is completed and the RBRVs have been subjected to the same rigorous review* that has been applied to the RBRVs developed in the first phase of the study.

The College of American Pathologists has communicated to the Physician Payment Review Commission on several occasions the need for a restudy of the resource-based relative values (RBRVs) of pathology services. We have met with William Hsiao, PhD, and are continuing discussions with him regarding parameters of a restudy. These discussions have been productive. The College Board of Governors has approved funding of the restudy based on a preliminary cost estimate provided by Dr. Hsiao. In his communications to us and to the Congress Dr. Hsiao indicates that he is confident that a mutually satisfactory agreement for restudy can be reached. We share that confidence.

Use of the current RBRVs for pathology services is clearly inappropriate given the many problems with data collection and cross-linkage for pathology that we have identified. Dr. Hsiao has indicated that a pathology restudy could be completed by the end of 1990. It is inequitable to implement a pathology RBRVs in advance of completion and review of the restudy.

In addition, a report on a relative value scale fee schedule for pathology services is being prepared by the Secretary of the Department of Health and Human Services, as required by the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203). This report could provide useful information on the relative values of pathology services.

2. We encourage the Subcommittee to reject *the PPRC recommendation for a short (six month) RBRVs start-up period* regardless of when authorizing legislation is enacted.

We oppose implementation of a pathology RBRVs on April 1, 1990, and until the Hsiao restudy of pathology services is completed and has been subjected to rigorous review.

The Commission recommends enactment of legislation this year to establish a Medicare fee schedule based on RBRVs with implementation six months after enactment and a two-year transition period.

We believe there are ample examples in Medicare program history to support a conclusion that implementation of an RBRVs fee schedule will be characterized by disruption and confusion among physicians, Medicare carriers, and Medicare beneficiaries. Implementation of such a revolutionary change without adequate preparation by the Health Care Financing Administration and carriers and with inadequate attention to communication to physicians and beneficiaries will only worsen the disruption that the change will produce.

We do not believe that a six-month period from authorizing legislation to implementation date is adequate for preparation and communication about the change. For example, if the Medicare Participation program is to continue then equity would require that physicians be given an opportunity to sign or rescind participation agreements based on knowledge of new fee schedule amounts. We do not believe that Medicare carriers would be able to establish the new payment methodology and provide physicians with the information necessary to a participation decision within six months of enactment of legislation.

3. We *support and appreciate the decision of the Commission not to recommend mandatory assignment.* We believe that Commission staff analysis of current balance billing characteristics demonstrates that balance billing amounts are not a problem for pathology services. Likewise mandatory assignment for pathology services would do little to reduce the out-of-pocket medical expenses that beneficiaries incur.

It has been suggested that balance billing is inappropriate in the context of a Medicare fee schedule that seeks to rationalize payment among services and physicians. We believe that it is inappropriate to mandate assignment in the context of a new payment methodology, untested and as yet incomplete, that will likely require refinement and adjustment.

4. We *support the Commission statement that a national fee schedule requires that codes for physician services be interpreted uniformly* by all physicians and carriers. We believe that physicians who provide the services described by the codes should determine how services are coded and be involved in any effort to define coding policy. RBRVs for pathology services should not be implemented until ambiguities in coding interpretation and use of surgical pathology codes have been resolved.

5. The College *supports the development of clinically relevant practice guidelines* that respond to questions of utilization of laboratory tests. We believe that physicians knowledgeable in applications and limitations of laboratory testing are the appropriate source of such guidelines. Federal funding for private sector physician-development of practice guidelines could produce clinically sound guidance that physicians can integrate into their practices. Toward that goal, the College sponsored a Consensus Conference on Appropriate Laboratory Testing Guidelines in March 1989. Representatives of medical specialties, the Blue Cross/Blue Shield Association, government agencies, industry and labor participated in what we believe was a productive first step in development of appropriate laboratory testing parameters.

6. The College *opposes expenditure targets for physician services.* The Commission recommends a national expenditure target under Part B to be used to determine annual conversion factor updates under the fee schedule. The target would reflect, in part, a decision concerning the appropriate rate of increase in volume of services per enrollee that would reflect tradeoffs between beneficiary needs, technological advances, and affordability.

The College believes that physicians must share the responsibilities of balancing escalating costs, responding to questions of utilization, and assuring access to needed health care services. Practice guidelines, appropriately developed and applied, hold promise for ensuring that needed care is provided and unnecessary services curtailed. The Commission also recommends other policies intended to reimburse physicians and beneficiaries appropriately for needed services, such as realignment of relative values of payment levels, new definitions of some service codes and service groupings, and development of practice cost and geographic variation factors.

To impose upon this network of new payment methodologies a rationing mechanism such as expenditure targets is a radical departure from the Medicare program commitment to provide beneficiaries with (covered) medically reasonable and necessary services. When implemented in the context of Medicare policy intended to identify and pay for needed services only, an expenditure target would implicitly sanction withholding of payment for services that are needed. The obvious product of an expenditure target would be an incentive to ration needed services.

We encourage the Subcommittee not to adopt the PPRC recommendation for use of expenditure targets.

FISCAL YEAR 1990 FREEZE PROPOSALS

The College opposes elimination of the MEI update for nonprimary care services.

The Administration proposes that nonprimary care services receive no prevailing charge update in 1990. Nonprimary care services are defined as services other than physician visits provided in an office, nursing home, home, or emergency department setting. The Medicare Economic Index is an inflation index used to limit updates in prevailing charges to increases in overhead and general wage levels. Nonprimary care services are affected by inflation in overhead and other costs just as are primary care services. There is no credible evidence that pathology physician services are overpriced. We believe it is inequitable to forego the scheduled MEI update for pathology services.

The College would also oppose any proposal to freeze clinical diagnostic laboratory services in 1990. Payment for these services has been the subject of numerous reductions and limitations in recent years. In 1984 Congress radically changed the payment methodology for Medicare clinical diagnostic laboratory services. In every budget reconciliation act since 1984 the Medicare fee schedule for these services has been subjected to additional restrictions, reductions, rebasing, or ceilings. Further restrictions could seriously compromise the quality of clinical diagnostic laboratory services.

CONCLUSION

The College of American Pathologists urges caution in early implementation of a RBRVs. In particular, pathology services should not be included in an RBRVs until the Hsiao restudy of pathology is completed and subjected to the same rigorous review that has been applied to other parts of his work.

We oppose freezing of pathology physician services and clinical diagnostic laboratory services in 1990. These services are subject to the same inflation as other services and should receive their scheduled updates.

Thank you for the opportunity to comment on PPRC 1989 recommendations and Administration budget proposals for 1990.

STATEMENT OF THE HEALTH INDUSTRY MANUFACTURERS ASSOCIATION

The Health Industry Manufacturers Association, known as HIMA, is pleased to have the opportunity to present our written statement on physician payment reform.

HIMA is a national trade association representing more than 325 manufacturers of medical devices, diagnostic products, and health care information systems. These are technologies used by physicians—and increasingly by physicians in their offices.

Our statement speaks to one issue—the resource-based relative value scale (RVS)—and makes one point: As the Subcommittee works to make an RVS fair and effective for physicians, it should work also to make an RVS fair and effective for the tools physicians need to help patients.

The Physician Payment Review Commission's work on RVS, and that of Professor Hsiao, are thoughtful attempts to build a better system for physician payment. But this system will not be better unless at least two things are true:

- The original construction is sound.
- The system keeps working over time.

Our statement speaks to both these points. We are pleased that the Physician Payment Review Commission has taken significant steps to address these points. We urge the Subcommittee to do so as well.

I. RVS CONSTRUCTION ISSUES: MAKING PRACTICE COST DATA MORE ACCURATE

Fundamentally, construction of a resource-based RVS should reflect just that: The resources physicians need to do their jobs. The Hsiao RVS attempts to do this in several ways. For now, we focus on his methodology for determining physician practice costs.

Identifying a physician's practice costs for technology is sometimes elusive:

- Use of medical technology varies by physician service and procedure.
- Use of medical technology varies (and increasingly so) by site of care.

Failure to address these complexities could result in incorrect judgments as to how much should be paid and confusion as to what is being paid for. It could also inappropriately skew decisions of physicians about what technologies to acquire and decisions of innovators about what research areas to pursue.

We are pleased that the Physician Payment Review Commission is exploring a methodology that would more precisely account for technology used by physicians. We support this and have been pleased to work with the Commission to facilitate a pilot survey to measure more accurately the technology component of practice costs.

We add our own thoughts below:

A. USE MORE CURRENT DATA

Professor Hsiao used the HCFA Physician Practice Cost and Income Survey. This survey collected cost data that was already five years old when the Hsiao report was released in 1988. And while Professor Hsiao, for that five-year period, assumed a relatively constant level of technology, it is far from clear that this basic assumption is correct. Moreover, his assumption that technology was uniform within and across specialties is to us suspect.

Three broad measures point up how much can happen in five years:

- Between fiscal year 1985 and 1988, the Food and Drug Administration approved more than 200 premarket approval applications (PMAs) for new medical devices. PMAs are required for devices that represent significant technological change.
- Between January 1983 and May 1988, HCFA issued more than 70 national Medicare coverage decisions. Most if not all of these decisions caused a change in the package of products and procedures that Medicare considers good medicine.
- In April 1987, HCFA significantly expanded the number of Medicare-covered ambulatory surgical center procedures, as evidenced by a four-fold increase from 400 to 1,600—in the number of codes for these procedures.

To be sure, none of these trends can be tied with precision to physician practice costs. They nonetheless underscore what intuitively we know to be true: Medicine has changed significantly in the last five years.

In addition to these trends, we note below more specific ways technologies have affected physician practice costs since the 1983 HCFA survey was conducted:

- *New Technologies Have Been Introduced.* Some technologies simply weren't being used (or used widely) at the time of the 1983 survey. In this category is use of lasers for cataract removal, a procedure now commonly employed to improve vision.
- *Existing Technologies Have Been Used For New Indications.* Other technologies, though in existence in 1983, were used in the years that followed to address new kinds of medical problems. Arthroscopic devices, for example, were used for knee surgery in 1983. But since then, incremental improvements in the device have allowed arthroscopy to be performed on wrists and temporomandibular joints.

Existing Technologies Have Been Used At New Sites. Doppler ultrasound permits non-invasive monitoring of cardiac output. Since 1983, many of these procedures have moved to physicians' offices from other sites of care.

Use of Supply Items Has Changed, Too. The examples above are at the upper reaches of technology. But changes have occurred in lower technology items, too. For example, AIDs has significantly increased the use of gloves, which physicians and their employees now wear during a wide range of medical and surgical interventions.

And finally, examples like those above make it hard for us to concur in Professor Hsiao's assumption that technology costs among specialties have stayed the same in a relative sense. For this to be true, technological change would have had to occur uniformly across specialties, across procedures within specialties, and across geographic areas. We believe innovation is too dynamic and pluralistic to conform to such neat symmetry.

In sum, the data accounts neither for technological change itself nor for its variation across medical specialties, procedures, and geographic areas. Without more current data, an RVS cannot adequately capture the physician practice costs the system is supposed to measure.

We recommend no RVS be implemented until it can be constructed with better current data.

B. USE A MORE PRECISE METHODOLOGY

1. A More Precise Survey

The HCFA data used by Hsiao is not only out of date; it is imprecise in what it measures:

- The survey did not request costs of specific medical technologies, only of overall equipment and supplies purchased.
- The survey may not have captured depreciation costs of equipment purchased in a year other than the year the survey was conducted.
- Price and volume may be inversely related. As the volume of products being purchased by a physician increases, the unit price may well decline. The same principle applies to the volume of procedures a physician provides. The more procedures across which the physician's costs can be spread, the lower the cost per procedure. It is not clear to us that Hsiao's survey reflects these subtleties.

But if it is unclear what is being measured, one point stands unambiguous: The survey used by Professor Hsiao does not adequately reflect the costs of a physician's technological resources.

2. A More Precise Allocation System

HIMA believes a physician's technological resources should in some fashion be tied to the individual procedures in which those resources are used. While we need to study further the Commission's methodology for incorporating practice costs into the RVS, it appears to allocate practice costs more precise than Professor Hsiao's approach. We comment on Professor Hsiao's approach below.

As the Commission has pointed out, the Hsiao methodology is built around average practice costs for each medical *specialty.* Thus, Professor Hsiao allocates the practice costs for use of technology for a given procedure at the same rate for all procedures in that specialty, even though procedures within a specialty (and their technological components) may differ radically. Said another way: Each physician in the same specialty is assumed to be using the same technological resources, regardless of what procedure he is performing or where he is performing it. For example, the RVS payment (based on the Hsiao methodology) to a dermatologist for surgical removal of a port wine stain would assume the dermatologist uses the same level of technology as all other dermatologists in all other dermatology procedures. Yet to remove the port wine stain, a laser is used, and this will cost more than the average technology cost Hsiao assumes for each dermatology procedure. And even for those dermatologists who use lasers, there are different kinds of lasers. Bottom line: Some dermatologists will be overcompensated, others undercompensated.

That is the basic problem. But the basic problem may be aggravated by another aspect of the Hsiao methodology—the way practice costs for a specialty are associated with procedures in that specialty.

As the Commission has noted, Professor Hsiao assigns a specialty's practice costs (including assumed costs of technology) to each procedure in the specialty at a rate that is proportional to the "total work" (a separate tributary of the RVS formula) required for that procedure. The assumption is that technology costs will be high where total work is high and low where total work is low.

Reality, however, may stubbornly resist such a neat pattern. Total work—time, mental effort, technical skill—may, in at least some instances, be *inversely* related to costs of technological resources. For example, an arthroscope can reduce a physician's total surgical time. Yet under the Hsiao methodology, a surgeon who invests in an arthroscope, and whose total work is thus lowered, will be incorrectly assumed to have realized a concomitant reduction in technology costs.

Dr. Hsiao has acknowledged that technology-intensive procedures are undervalued. He suggests addressing this problem through the "conversion factor," the multiplier that would convert RVS weights to dollars. This, however, would raise the system's accounting for technological resources to a more global (and less precise) level.

Our recommendation goes the other way. We prefer the Commission's service-specific methodology, which more closely ties a physician's technological resources to the individual procedures in which those resources are used. Again, we reserve final judgment until we can more thoroughly analyze the Commission's work.

II. RVS Maintenance Issues: Allowing Physicians to Get the Tools They Need

An RVS system must not only be constructed well. It must keep working well over time. We are pleased that the Commission recognizes the importance of this.

Health care, like most things, is not static. Nor should it be. Does anyone want to go back to the care we had a decade ago? To that of five years ago? And what about what we have today? Freezing the current level of technology is no more attractive than using iron lungs to fight polio.

An RVS must capture health care's changes in a timely, effective, and fair way. If this is not done, and done systematically, the dynamism of medicine will collide with the rigidity of regulation, producing requests for an RVS overhaul.

It is to us instructive that the Prospective Payment Assessment Commission (ProPAC), now five years into its experience with DRG's, has recognized the importance of a payment system flexible enough to keep pace with changing medicine:

- With about 2½ years of DRG experience available to it, ProPAC, in 1986, said this:

> [A] recalibration schedule should be set in advance so that the hospital industry can anticipate when changes in the weights will occur . . . Given how quickly practice pattern changes that affect relative resource use among the DRGs can occur, the four-year maximum cycle is clearly too long to keep the weights current. Even with an annual cycle, the most current patient billing data will be two years older than the year for which the weights are set.

- Also in 1986, ProPAC recommended annual recalibration of the DRG weights, finding these adjustments "necessary to account for changes in medical practice, technology and . . . coding." (The law was amended to make this change.)

Keeping an RVS system current is in at least some ways more challenging than keeping DRG's current.

The data on which DRG system changes are based are hospital charges and/or costs. This is information hospitals routinely compile. And it is information HCFA routinely collects on an annual basis. Thus, as charge and/or cost data is received by HCFA and recorded, it can be used to make changes in the DRG weights and classifications.

The data source for a resource-based RVS, however, is not so readily available, since the key, underlying factors are physicians' total work and practice costs. Unlike hospital charges and/or costs, data on physicians' total work and practice costs is not routinely or easily collected. It can be acquired only through complex and painstaking surveys (witness the extent of Professor Hsiao's own total work).

These difficulties, however, make an up-to-date RVS no less important. While the Commission has begun to address this issue, we suggest the Subcommittee and the Commission explore the following specific approaches:

A. AN INTERIM, MORE IMMEDIATE ADJUSTMENT MECHANISM

We urge the Subcommittee to explore ways for an RVS to recognize new technologies on an interim, more immediate basis.

This is particularly important for RVS, since, as noted above, data on physicians' total work and practice costs must be acquired through time-consuming surveys. This means the data may be collected less frequently than is optimal, thus delaying recognition of new technologies unless an interim mechanism is in place.

Such a mechanism could allow new things to be coded and paid for temporarily until more complete, survey-based judgments could be made. During such an interim period, physicians and others could submit information that would allow the later judgments to be more informed.

What's the alternative? If past is prologue, the alternative is to wait—and to wait a long time for a decision to be made. A recent report by an HHS advisory committee, for example, found that new technologies queue up an average 2.4 years for a national Medicare coverage decision.

If unacceptable for an established regime like Medicare coverage, delays of this kind are inexcusable for a system we now have the power to shape. RVS is such a system. It should be shaped to avoid delay and to facilitate integration of changing medical practice. An interim mechanism may be one way to accomplish this.

B. MECHANISMS FOR UPDATING THE SYSTEM

In addition to an interim mechanism, the RVS system should be periodically updated. Among the mechanisms the Subcommittee should consider are an update to the conversion factor each year and a survey of physicians' total work and practice costs as frequently as is feasible.

C. ACCURATE AND CREDIBLE CRITERIA

The interim adjustment and updating mechanisms should be grounded in clear criteria that measure accurately, objectively, predictably—the resource and practice changes taking place in medicine. This is not an area that abides imprecision. For imprecision can breed caprice, and that can cause confidence in the system to fail.

The Subcommittee's goal should be to make RVS revisions—like the system being revised—as fair, effective, and predictable as possible.

III. CONCLUSION

We close as we began by saying that this RVS system, to be a better system, must be well constructed and carefully maintained. We stand ready to work with the Subcommittee on these and other important RVS issues.

STATEMENT OF THE MEDICAL GROUP MANAGEMENT ASSOCIATION

The Medical Group Management Association (MGMA), representing the administration of medical group practices across the country, appreciates this opportunity to comment on options for reform of the Medicare Part B physician payment system. We have worked with the Physician Payment Review Commission (PPRC) over the past two years, providing data for research, as well as input and feedback on policy proposals. Similarly, we look forward to working with the Congress as it considers the recent recommendations of the PPRC, as well as short-term Medicare budget cuts required by the budget resolution.

MGMA has nearly 4000 medical groups in its membership, representing almost 85,000 physicians, practicing in every specialty, and in all areas of the country. A demographic description of the membership is attached for your information.

FY 1990 BUDGET ISSUES

We are keenly aware of the difficult task Congress faces each year when debating the federal budget. Balancing priorities, assuring that federal programs are properly funded, and maintaining fairness in public policy are increasingly difficult after several years of increasingly severe reconciliation bills. MGMA is concerned that some of the proposals under consideration for Medicare in FY 1990 are inconsistent with long-term policy, and can be improved upon if further short-term cuts must be made.

Overpriced Procedures—MGMA opposes the proposed additional 12 percent reduction in payment for procedures the PPRC identified two years ago as "overpriced." The concept of reducing payment for designated procedures is sensible when targeted on physicians who are actually overpaid for the procedure. The proposal as written, however, would potentially penalize everyone performing the procedure.

Although the method used two years ago to calculate the reductions was complicated, it at least distinguished between those who received fees above the national average, and those whose fees were below the national average, and reduced allowable charges accordingly. If budget cuts must be made using this technique. It would be more equitable to use a similar method in determining how much such fees should be reduced.

Reductions in payments for radiology, anesthesiology, and surgery—For many of the same reasons, MGMA opposes the plan for an across-the-board reduction in payments for radiology, anesthesiology, and surgery. This eight-percent fee reduction unfairly penalizes those physicians who perform such services in low fee localities. The policy assumes that all such procedures are overpriced, which is simply not the case.

Across the board cuts are an arbitrary approach to reducing the Medicare budget. They are not based on sound Medicare policy, but rather on a piecemeal approach to balancing the Federal budget.

Fee Freeze—The proposed freeze on physician fee updates is inequitable and unreasonable. If a freeze were to be imposed, the federal government would again demonstrate to the physician community that it is an unreliable business partner. Physicians' fee updates should at least keep pace with inflation in the medical economy. Over the past several years, fee updates have not even been equal to the Medicare Economic Index (MEI), which itself is designed to keep physicians' fees down.

Since 1984, physicians' Medicare fees have not been allowed to increase normally. Instead, they have been artificially deflated, and as a result, are much lower in many cases, than fees for non-Medicare patients. A Medicare fee freeze will only exacerbate the problem. Just as hospitals have "cost shifted" to commercially insured and self-pay patients due to Part A payment reductions, so too are employers being asked to unfairly subsidize Part B of Medicare.

Payment ceilings for designated specialty services—The Administration's proposal to establish a ceiling on prevailing charges for services frequently performed by specialists is good in principle, although the proposal itself is very vague, and details obviously have not yet been considered.

If the idea is to assure that the highest fee is paid to the recognized expert for that particular service, the proposal makes good sense. As most Medicare fees are based on historical charges, under current law there is no assurance that a specialist would be paid more for a service than a generalist. We agree that the recognized expert's fee should be the ceiling.

PPRC RECOMMENDATIONS AND THE MEDICARE FEE SCHEDULE

MGMA supports the core concept of the study conducted by William C. Hsiao, PhD, on the development of a resource-based relative value scale (RBRVS); we believe it is appropriate to pay for a physician's service based on the resource input of that service. We commend the Commission for the work it performed following the release of the Hsiao study. The Commission's analysis was extensive, and its research methods sound.

We have three main concerns regarding the PPRC's recommendations to Congress, which involve: a transition from the current payment system to a fee schedule; changes in rules on balance billing; and the use of national expenditure targets.

Transition period—If Congress were to enact legislation calling for a national Medicare fee schedule, it would be vital to provide an adequate transition period to change from the current payment system. A reasonable transition period would be not less than three years from the date new regulations take effect. Just as a lengthy transition was necessary when hospitals changed from a reasonable cost payment system to a prospective payment system, medical groups will also need an appropriate adjustment period. If providers are to see a dramatic shift in income from the implementation of a fee schedule, this time will allow them to better prepare for the change.

Any change in the Medicare payment system usually requires a substantial amount of time for providers to adjust their billing or accounting systems. Providers are often the only source of information to the beneficiary about the Medicare program, so adequate time is also necessary to explain changes to their elderly patients.

Perhaps most importantly, the Part B carrier network which administers Medicare is overloaded to the point of "melt down". Carriers have not been able to keep pace with the volume of changes legislated since 1982, and unrealistic statutory deadlines have contributed to repeated instances of confusion and mistakes.

Balance billing—If a Medicare fee schedule is used in the future to pay for physician services, it should not be mandatory for physicians to accept the fee schedule amount as the charge limit. MGMA believes participation in the Medicare program should continue to be voluntary, and that balance billing should be allowed. Arbitrary price controls that result from mandatory assignment are unfair and unnecessary.

The average income for elderly Americans is much higher today than it was over 25 years ago when the Medicare program began. As demonstrated by a recent PPRC study on the effects of balance billings on the elderly, only about one percent of Medicare beneficiaries incur out-of-pocket medical costs of $1,000 or more due to balance billing.

The Congress must make every effort to keep Medicare rates competitive with other payers. Some medical groups have already begun to look to alternative means to maintain a reasonable profit margin. Techniques to manage payer mix, such as limiting the amount of time physicians spend with Medicare patients, or limiting the number of Medicare patients a physician could see in a day, are a few of the steps being taken to minimize financial loss when Medicare pays non-competitive rates. *Mandatory assignment in conjunction with a fee schedule would unfairly restrict the options of both beneficiaries and providers, and further impose on employer based coverage to subsidize care for the elderly.*

Expenditure targets—MGMA strongly opposes the institution of expenditure targets to control the growth in Medicare Part B costs. As advanced, this concept is a poor alternative to controlling the growth in spending for physician services. If it leads to true rationing it is the end of Medicare Part B's entitlement status. Beneficiaries are no longer truly insured, they are at the whim of annual appropriation. If instead it is just another guise for continued price controls, it is of the most arbitrary kind.

To expect individual physicians to embrace this concept as an opportunity to achieve the goal of volume reduction is naive. Those physicians who provide an excessive volume of services would continue to do so, while other physicians would suffer the consequences through diminished fee updates.

We are aware of the concern in Congress and in the Administration over the federal deficit, and we understand the need to control program costs. *However, capping expenditures at some figure derived by some formula still to be determined will do little more than limit the availability of services to Medicare patients, and penalize medical groups that responsibly control utilization through good management, internal peer review and effective patient/physician education.*

If Government is serious about controlling volume, it should join with the professions and the employer community to establish, through hard research and consensus building, practice standards that distinguish between what the Government is willing to pay for, and what should remain the patient's choice and financial responsibility.

In conclusion, MGMA hopes these issues are given serious consideration during the Fiscal Year 1990 budget debate and we would be happy to provide further information on these topics. We look forward to working with the Committee members in developing a fair and equitable budget plan for the Medicare program.

FACTS ABOUT MGMA'S MEMBERSHIP

There are 3904 MGMA group members.
Within those groups there are 82,954 physicians.

49.5% of those groups represent single specialty practices.
29.6% of those groups represent multi-specialty practices.
39% of MGMA group members report involvement in pre-paid care.
Of the member groups . . .

1805 have fewer than 6 physicians
971 have 6-10.9 physicians
528 11-20.9
248 21-35.9
98 36-50.9
122 51-100.9
31 101-150.9
27 151-200.9
74 201 or more

NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE

SUBMITTED BY MARTHA MC STEEN, INTERIM EXECUTIVE DIRECTOR

I am Martha McSteen, Interim Executive Director of the National Committee to Preserve Social Security and Medicare. The National Committee represents over five million members and supporters, most of whom are senior citizens. Physician payment reform is not only a pocketbook issue for the Medicare program and doctors, but it is also a pocketbook issue for senior citizens, who already spend 18 percent of income for out-of-pocket health care costs. While the Harvard researchers and the Physician Payment Review Commission have done valuable work, it is up to Congress to insure that these recommendations translate into more affordable and accessible health care for older Americans.

The National Committee has outlined beneficiary criteria for physician payment reform which includes financial protection, quality care, and information and assistance (see attached). We would hope that physician payment reform would provide Congress the opportunity to address all these issues, but at a minimum it should guarantee beneficiaries greater financial protection from doctor charges above what Medicare allows and Part B premium increases.

As we said in our statement last year, an overwhelming 72 percent of respondents to a National Committee member survey agreed the federal government should regulate doctor and hospital fees. Two thirds of the membership ranked, as one of their top two Medicare priorities, that doctors be required to accept assignment. Controlling premium increases was also a high priority.

We are disappointed that the Physician Payment Review Commission did not recommend limiting doctor charges to what Medicare allows. The Commission, however, has laid the groundwork for Congress to gradually phase in such a limit at the same time it is phasing in the payment reform. The Commission recommended limiting doctor fees to 20 percent more than what Medicare allows and increasing the Medicare allowable fees more for participating physicians than for other physicians. According to the Commission, these recommendations would reduce beneficiary out-of-pocket costs only $4.50 a month. Congress should go beyond the Commission's recommendation and reduce the 20 percent limitation five percent each year until all doctor charges are limited to what Medicare allows.

Past reports of the Commission have noted that the burden of doctor charges above what Medicare allows goes beyond the $3.1 billion a year in additional out-of-pocket costs for beneficiaries. Beneficiaries frequently don't know if their doctor will charge them additional amounts and, if so, by how much. Seriously ill patients face the largest bills and have the least choice of doctors. The new Medicare Catastrophic Coverage Act will provide little additional help for these expenses, which are usually not covered by private medigap insurance.

While considerably less than the last year's Part B premium increase of 38.5 percent, this year's premium increase of 12.5 percent (before the increase for catastrophic care) was more than triple the cost-of-living adjustment COLA) for Social Security benefits. If the premium for catastrophic is included, the premium increase is 28.6 percent. In other words, the premium has increased almost thirty percent in each of the last two years.

Beneficiaries have some reason to hope that next year basic premium increase (excluding catastrophic) will be no more than four percent because current law would limit the premium increase to no more than the COLA. Unfortunately, the Administration has proposed increasing Part B premiums to cover 25 percent of program costs which would cost beneficiaries $10.5 billion dollars over five years, or approximately $300 per beneficiary.

Congress has an opportunity to reform Medicare payments for doctors in a way that will assure that beneficiaries are financially protected, that doctors are paid equitably and that patients are assured access to high-quality medical care. The Physician Payment Review Commission report has given Congress a good foundation to achieve these goals.

Thank you.

Enclosure.

BENEFICIARY CRITERIA FOR PHYSICIAN PAYMENT REFORM

FINANCIAL PROTECTION

Limit doctor charges to what Medicare allows. Without a limit on doctor charges above what Medicare allows, the imposition of any fee schedule will do little more than serve as an open invitation to doctors to "balance bill" beneficiaries to compensate themselves for lost income. This is a particular danger with regard to specialty surgeons; their record on accepting assignment has been the worst, and now, under any conceivable fee schedule imposed by Congress, they stand to lose the most.

Limit Part B premium increases. Increases in Part B premiums should be tied to—and no larger than—increases in the Social Security cost-of-living adjustment (COLA), as provided for under current law for 1990 and future years. Medicare beneficiaries pay $382.80 per year in Part 8 premiums alone. This will be the minimum out-of-pocket cost for a healthy Senior who does not visit a doctor even once for an entire year. The Administration's proposal to increase Part B premiums to cover 25 percent of program costs would cost beneficiaries $10.5 billion over five years.

QUALITY CARE

Assure that care is necessary and appropriate. Since 1972, Medicare has relied on utilization review to identify unnecessary or inappropriate care. It has not worked well, and the Physician Payment Review Commission concluded that, as currently practiced by Medicare, it can't—"without risk of reducing quality of care." The commission favors a clearer focus, more research and less secrecy.

Assure that care meets quality standards. The only leverage that Medicare has is to deny payment to doctors who provide substandard medical care. In 1986 Congress ordered Medicare to actually start doing this. Implementing regulations have only been recently propose and they would provide for the denial of payment only when medical care results in "actual, significant, adverse effect."

According to the Physician Payment Review Commission, the peer renew organizations (PROS) whose job it is to watchdog doctors have failed to do so. Its report cited a HCFA finding that half the PROs "failed" their contractor performance evaluations because they had done nothing about the instances of inept or harmful medical care they had discovered.

INFORMATION AND ASSISTANCE

Make program rules clear and understandable. Abolish needlessly complex rules (e.g., the MAAC) that are incomprehensible and annoying to patients and doctors alike. Agency and carrier communications to beneficiaries should be clear and understandable, timely and polite.

Assist beneficiaries in filing claims and appeals. Restore Medicare's practice of offering help to beneficiaries in local Social Security offices. Encourage Medicare carriers to undertake efforts in "beneficiary outreach," as suggested by the Physician Payment Review Commission.

Publicize clinical criteria and physician performance data. Throughout its report to Congress, the Physician Payment Review Commission calls upon beneficiaries to help reduce the volume and intensity of medical services, and to help eliminate services of marginal value. The Commission acknowledges the obvious fact that doctors are the key decision-makers. Nevertheless, it wants beneficiaries, their families and organizations to somehow help control doctors' prices and doctors' behavior. This is not remotely possible unless beneficiaries and advocates have the data and information on which to base informed decisions.

STATEMENT OF WILLIAM J. RAND, M.D.

Congress is currently evaluating options for far reaching changes in physician reimbursement for services rendered to Medicare patients. Perhaps the ophthalmologist's perspective is more focused, because any changes in Medicare impact more severely upon ophthalmology. As an ophthalmologist, my practice consists of more than 95% Medicare age patients.

It is certain that changes must be enacted to preserve the Medicare program, to effect cost containment, and to curb system abuses. However, some of the solutions being advocated, will lead to the destruction of "centers of professional excellence." These centers are a small, but essential element of our medical system. They drive our standards towards excellence and provide most of the innovations and technological achievements that occur in American medicine today.

The centers of professional excellence (COPE's) are the most fragile element of the health care system and will be the first to perish if they are not looked after. The COPE's traditionally have funded themselves by not accepting Medicare assignment and charging more for their services than the assignment amount. They have been economically injured by previous congressional action that restricted the fees they may charge Medicare patients (MAAC's and Special Charge Limits) to the point where the level of service exceeds what they are allowed to charge. It is informative to note that the MAACs and special charge limits have caused the most financial loss for the COPE's and yet they were purely administrative regulations that did not provide even one dollar of savings to the government or to Medicare.

It is the intent of this testimony to provide congress with information that it will need in order to preserve the excellence in ophthalmology as well as in the other fields of medicine.

There are two types of centers of professional excellence (or COPE's):

(1) The traditional university centers, or medical school affiliated eye institutes are the well known university affiliated COPE's. They are a vital resource for the training of new ophthalmologists and for carrying out basic science research programs. Most of these institutions started out and were developed from clinical COPE's.

(2) The clinical centers of professional excellence are smaller and usually newer centers of professional excellence. These centers are more patient oriented. The clinical COPE's provide an extra level of clinical and surgical care and they engage in significant research, development, technical innovation and high level post graduate education.

The Rand Eye Institute (REI), located in Pompano Beach, Florida, is representative of, and may serve as a model for a clinical COPE. A much higher level of clinical care is provided. Let me explain:

A patient visit at a private practice ophthalmologist typically takes 10–20 minutes, including taking a history, checking the refraction, the ophthalmological examination, informing the patient of the nature of his or her problem, answering questions, and giving instructions. Some ophthalmologists will have an assistant helping them but many do everything themselves.

At the Rand Eye Institute, an examination may take an hour or longer of actual examination time. A technician typically spends 15 minutes acquiring and organizing a detailed patient history. An optometrist spends 20 to 40 minutes or longer if necessary, gathering appropriate technical data and checking the refractive status of the eye. A research fellow analyzes data and correlates it with clinical research studies. The exam is completed by a Board Certified ophthalmologist who spends between 10 and 20 minutes with the patient. A medical assistant takes orders from the ophthalmologist and explains and writes out the instructions for the patient (10 minutes), so there will be no mistakes or misunderstandings. The patient is then escorted to view pertinent videodisc material regarding his or her eye condition.

The patient care at the Rand Eye Institute represents a more intense level of care. This additional level of care merits an additional level of reimbursement, whether it comes from Medicare or from balance billing of the patient. The Rand Eye Institute can only charge an artificially mandated MAAC allowable charge of $66.31 for a comprehensive office examination. This does not adequately reimburse the Rand Eye Institute for the service provided. In the past, patients had the option of paying more for higher levels of care if they desired. This is no longer permitted because of the MAAC limits. Even a wealthy individual can not legally pay more if he has Medicare.

This loss of revenue hurts the COPE's and interferes with their ability to render extraordinary care. This is a result of an artificially leveled playing field. The same ophthalmologic services rendered by different providers are not necessarily equal, meriting an equality of fee schedules, because the providers provide different levels of intensity and quality.

Small clinical COPE's have been the source of most of the modern surgical advances that have so much benefited the people of this country, most notably in the field of ophthalmology. Virtually all the advances in cataract surgery over the past 20 years, including lens implants and microsurgery, were developed, perfected and disseminated to the profession through the research, development and education commitments of these centers of professional excellence. It is significant to note that these advances did not come from the established university or medical school affiliated research centers. They came from the minds and dedication to excellence of the surgeon directors of these small COPE institutions.

The centers of professional excellence characteristically solicit no federal funding other than the fees they collect for services rendered. They are funded by revenues generated by their individual physicians. Rather than profiting maximally from their private practices, these physician specialists invest much of their financial resources and time and effort in research in the clinical sciences, technological development, innovation and post graduate education endeavors that significantly benefit the people of this country. As such, these physicians and their COPE's constitute a true national resource.

The physician founders of these COPE's are invariably ethical and moral individuals who are literally fixated upon the perfection of their art and science with a dedication to quality in medicine that is extreme in it's application. It is important not to confuse these leading specialists with the so called buccaneer surgeons.

Traditionally, the clinical COPE's have been founded by physicians who possess and develop skills and expertise far beyond their peers. Because of this, patients seek out these physicians for their expertise, generally pay a premium fee for these higher levels of service, and consider themselves fortunate to be able to be in their care. These leading surgeons offer a greater level of experience and skill and generally produce finer results with less damage to the eye, quicker recovery, and a lower complication rate.

Many difficult operations that other eye surgeons had put off or considered to be impossible have been performed almost routinely at the Rand Eye Institute. It will be five years or more before most eye surgeons in this country can adapt into the newer and more difficult and complex cataract surgical procedures already utilized as standard procedures at the REI. Many of the eye surgeons practicing today will never be able to learn these complex new procedures. Those that do learn them, will have to take courses and study video tapes produced by COPE's such as the Rand Eye Institute.

The surgical care provided at COPE's such as the Rand Eye Institute is of a significantly higher level than the surgical care provided by average ophthalmologists and as such merits a higher level of reimbursement. These additional revenues support the research and education endeavors of the institute and they facilitate the ready acquisition of new equipment. Traditionally, patients have been eager to pay more than their insurance allows for the privilege of gaining access to the surgeon they perceive to be the best. Over more than 5000 operations, no patient has ever suggested that they felt that a surgical fee was unreasonable. Instead, we have collected stacks and stacks of letters of gratitude which proudly adorn the walls of the Rand Eye Institute.

Congress enacted legislation that effectively limited Medicare's payments for physician services to approximately 1984 levels. Subsequently a relatively painful 12% reduction in Medicare reimbursement for cataract surgery was mandated. But it did not stop there. Without saving Medicare or the government anything, the MAACs and special charge limits were mandated and these regulations have severely hurt the COPE's.

In this first year of complete implementation the special charge limits for cataract surgery with lens implantation, my surgical fee (code 66984) for Medicare patients, can not be more than 25% above the Medicare allowable amount. My surgical fee has been reduced from $2750, my normal fee for non Medicare patients, down to $1847.75 a reduction of 33%. This may be more of a reduction than Congress had intended. And not one dollar was saved by the additional massive fee cut required by the special charge limit, which happens to be even $400 less than the MAAC amount.

This one "specialty" procedure, cataract surgery, is responsible for much of the revenue generated at the Rand Eye Institute. And 95% of these patients are Medicare patients. As a result, there has been disruption of many of the Rand Eye Institute programs. Staff has been laid off or not replaced. Research and education activities have been scaled down. The construction of our new $4,000,000 state-of-the-art facility has been halted and is being reassessed for feasibility.

Planning is virtually impossible because no one knows what cuts or restrictions will come next.

The centers of professional excellence must have special consideration or exemption from legislative action in order to allow these institutions to grow. If this is not done, the golden age of progress we have enjoyed will come to an end. Future COPE's will never develop. It would be unfortunate if we will have to look back and see that the most advanced ideas in surgery were never developed.

In making alterations to the Health Care System, Congress should assure that:

(1) Health care should be accessible and affordable for the greatest number of people possible.

(2) The Medicare system should be maintained as a solvent and affordable system through responsible cost containment measures.

(3) Patients should be assured of access to a physician of their choice, without unnecessary delay.

(4) Patients should be assured of access to hospital based care and necessary surgical procedures without unnecessary delay.

(5) The established eye institutes and universities, that serve as a resource for basic science research and for the training of the next generation of medical and surgical eye physicians, should be preserved.

(6) The Centers of Professional Excellence, that provide a higher standard of medical care and serve as a resource for research, development, education and technological innovations in the applied medical and surgical clinical sciences, should be preserved.

(7) The next generation of eye institutions should be encouraged, not undermined in the name of cost containment.

The "American medical care system" is a complex and interdependent system. There are problems that do require solutions. But this should not detract from the basic premise that the system does work. It provides most Americans with the most sophisticated and highest standard of health care available worldwide. Health care in America is usually provided by humane, interested and concerned individuals and is usually available without delay.

Much discussion has taken place regarding the shortcomings of the free enterprise system of delivering health care in this country. Little attention has been given to the many positive attributes of current health care. This is understandable since repairmen seldom center their attention on the parts that work. It is important, however, not to lose sight of the successes of the American health care system.

Our system is a magnet for patients from around the world, who come to the United States for treatments that could have been obtained free of cost if they would accept the standard of care provided in their own countries. I have performed surgical procedures for patients who have traveled from countries such as England, Canada, Israel, and Bangladesh.

Virtually all technology based achievement in the field of medicine today, originates from the United States. Other countries may have knowledgeable physicians, but they are not motivated or financially able to assertively seek excellence in their fields through research and development and hard work. The only medical advances produced outside of the United States today, are non technology based procedures, or technology innovations that are produced and targeted for the lucrative American medical marketplace.

The socialized medical systems of the world depend upon American Technology, buying lasers and other sophisticated machines that remain inexpensive only because they are mass produced and widely placed in numerous American physician's offices and hospitals.

Members of Congress may have a number of well intentioned misperceptions of the realities of ophthalmological (eye) care. This is not surprising since much misinformation exists in the general population. The medical science of ophthalmology is difficult to understand due to it's scientific and technological nature. The public is prone to great interest in ophthalmology due to the vital nature of eyesight. one of the greatest fears everyone has, is the fear of blindness. And the media has shown great interest in the exploitation of these fears and incorrect perceptions.

A misperception exists that cataract surgery represents some newer, faster and easier procedure, different from procedures of the past. If this is true than it would not be worthy of the same level of reimbursement. This could not be further from the truth.

In fact, today's modern methods of cataract microsurgery require more intricate and complex surgical manipulations and skill, training and concentration than at any other time in history. Ten minute cataract operations have been performed by master surgeons since the time of Castroviejo, Saskin and Barraquer, 35 years ago. Most eye surgeons today still require an hour for their cataract procedures. Many of today's eye surgeons will not ever be able to make the transformation to the newer, even more complex and difficult small incision cataract surgery methods.

Overeager, overambitious physicians through advertising, helped to give the impression that the surgery was easy and simple. But there never really was a new or easier operation. Innovations in technology, mostly in anesthesiology techniques, do indeed make the surgery seem painless and easy for the patient.

Advertisements for cost free surgery were only natural, since the surgery really was cost free to the patient. Previously, Medicare encouraged out patient surgery by paying 100% of the cost, if the doctor accepted assignment. Such advertising no longer occurs because Congress restored the 20% copayment requirements for outpatient surgery.

Much misinformation has been propagated by inaccurate newspaper and magazine articles such as one that appeared in Readers Digest, (Dec. 1988), which provided an erroneous and misinformed indictment of ophthalmology and it's leading eye surgeons. This article did not distinguish the leading surgeons from the occasional buccaneer surgeon. The distortions and innuendoes of this article were so appalling that many patients deferred their eye surgery. Many doctors reported diminished surgical caseloads in the months that followed.

Congressional hearings also received reports that there are many surgeons who perform unnecessary cataract surgery. It would be impossible for even the most unethical surgeon to be able to convince a large number of patients to allow him to operate upon their eyes if they did not perceive a significant problem with their eyesight. The problem could not be as widespread as has been suggested.

When is surgery necessary? Cataract surgery is performed earlier than was the case in the past. This is because the operation now achieves better visual results with less risk and morbidity. Surgery is considered necessary when the quality of life is impaired sufficiently enough to make it worth accepting the risk of the surgery. In cataract surgery, surgery is usually needed when visual acuity is reduced to the 20/50 to 20/70 level under common lighting conditions, including glare producing situations. Surgery is only recommended when the patient perceives a significant problem.

Some cataract patients can read as well as 20/30 or better if they are tested in a darkened room. However, when fluorescent lighting or sunlight hits their eyes, some of these patients will suffer a glare induced reduction of their vision well below the 20/50 level, making them a hazard when driving and impairing their productivity and quality of life.

The ability to test and measure this "glare disability phenomenon" is relatively new. New devices such as the brightness acuity tester (BAT) and contrast sensitivity measurement (Vistech) unit can accurately measure how much visual impairment the patient is suffering.

The average ophthalmologist performs only 50 to 75 cataract operations per year. One fourth or more of all ophthalmologists are only occasional surgeons, performing less than two to four operations per month. Many physicians perform older surgical procedures with greater risks and lesser results. Many have not yet acquired any glare disability measuring devices.

Sadly, more than a few ophthalmologists do not even understand the concept of glare disability nor do they see enough cataract patients and hear their sufferings enough to know to even refer these patients for glare disability testing.

Much of the criticism regarding surgery abuses can be attributed to a disgruntled minority of occasional eye surgeons, ignorant of the concepts of glare disability and patient suffering. They, themselves, are hurting their patients by withholding surgery until the patient either reaches the point of desperation or seeks care in the hands of a more knowledgeable surgeon. These Doctors are the most likely and the least qualified to make allegations against their peers.

I have operated upon many high risk complex eye conditions in patients that other ophthalmologists had considered to be inoperable because they were not even aware that there were newer and safer (but not easier) microsurgical procedures.

Some of the studies that have been prepared for the Congress are unscientific in their methodology and in their conclusions. Many of these studies are being prepared by personnel who are not practicing physicians. The studies may be given undeserved credibility because the senior researchers are employed by a respected and prestigious university. The methodology, and many of the conclusions of these studies have been challenged.

In one example, the researchers concluded that eye surgeons had undertaken to perform more surgeries and more complex procedures in order to overcome the effects of the 1984 fee freeze and subsequent fee restrictions.

By 1984, many eye surgeons were in the process of converting to the more complex and difficult extracapsular methods of cataract surgery. Extracapsular surgery was safer. And with the newer posterior chamber implants, for the first time, a permanent return to truly normal vision could be obtained. As the risk of the surgery declined, and as the results improved, it became unnecessary for patients to suffer excessively with a cataract. Therefore, more patients were eligible for cataract surgery. Of course, the additional procedure of lens implantation was added to nearly all cataract procedure because it became malpractice to not use a lens implant.

To suggest that the passage of new fee restrictions induced ophthalmologists as a group, to perform more procedures and to add lens implants to their cataract operations, illustrates a lack of knowledge of the whole field of ophthalmic surgery. It is sad but not surprising, that the researchers could only conclude that the increased volume of services and the use of lens implants were due to economic reasons.

Congress and it's appointed committees should retain a level of healthy skepticism for new ideas involving health care planning, especially when suggestions for change come from individuals with primarily economic backgrounds. Experience shows that their perspective may be limited to their own field of expertise. The consequences of misdirected regulatory and fee restrictive action could be catastrophic for the continuation of a system of excellence in health care.

So many people today owe a debt of gratitude to a very special group of dedicated individuals. Modern ophthalmology can be proud of the eyesight restored; the millions of American lives made brighter and more productive; the widespread alleviation of suffering and human misery; the constant research and development commitment for the benefit of mankind. It is my hope that your Subcommittee and Congress will keep these overriding considerations in mind in its deliberations on physician payment reforms as they may affect ophthalmologists and the centers of professional excellence.

In addition, I would like to offer some general recommendations for improving our health care system.

(1) Congress should assure the fiscal integrity of the Medicare system by responsible cost containment measures.

Expenditure targets may be unpalatable, but necessary. If it is necessary to implement a percentage reduction for Medicare savings, the required percentage reduction should be calculated evenly spread out over all providers. A precedent for this exists in the prior implementation of automatic Gramm-Rudman reductions. These reductions would not shock the system.

(2) Patients of limited income must be protected from increased costs that might result from future actions. This can be accomplished by a program of voluntary Medicare assignment for low income Medicare patients. This can be made mandatory, if necessary.

A special identification card could be issued to each Medicare recipient with an income of less than $12,000 per year. Most physicians would welcome the opportunity to know which patients need special consideration and would cooperate willingly.

It is not necessary to restrict fees except to protect those with financial hardship. There is no shortage of physicians who will gladly accept Medicare assignment for all services, even with reductions. Very few doctors work at capacity. Only those patients who want to pay more for a specific individual physician will do so and they can change doctors if they do not want to pay more. Currently, 79% of all Medicare claims in the state of Florida are being sent in on assignment. For surgery, it is well over 90%.

(3) Congress should require that any surgical service that might be suspected of abuse be pre-approved, not by a PRO, but by the patient, utilizing a system of informed consents.

Presently, cataract surgery is pre-approved by communicating by mail or over the phone or by fax with a secretary or nurse at the PRO, who verifies that the exam data confirms the indication for surgery. At this time, the Florida PRO is not answering the phone and many of my patients are finding their surgical dates canceled for lack of an approval number.

The PRO staff merely checks the examination data against a list of guidelines. A patient could do this better and would be more interested in confirming the indications for surgery. Therefore, this costly PRO system could be replaced with a more effective patient oriented system.

The patient can be required to read, understand and sign an informed consent document that lists the criteria for surgery. A witness other than the physician should sign as well. The original document can be required to be attached to the Medicare claim form for payment.

(4) Congress should address the issue of cost containment in medical malpractice insurance premiums. Virtually anyone can obtain a $25,000 settlement for an alleged injury since it costs much more for an insurance carrier to litigate a valid defense.

Congress should establish system of out of court arbitration panels and encourage the definition of a list of potential complications that can occur as a consequence of medical or surgical treatment that would be considered to be non litagatable occurances.

(5) Congress should attempt to assure the availability of affordable health insurance for anyone who wants it.

Congress should consider giving U.S. citizens the option to purchase into the Medicare or Medicaid plans for an annual premium. Rates could be set on a sliding scale according to personal income with annual adjustments for inflation. Medicare benefits could be priced higher than Medicaid, with selection of options at the discretion of the purchaser. Limitations of expense could be based upon a certain percentage of income.

This would be particularly beneficial for those who might be denied insurance for pre-existing medical conditions such as diabetes or heart conditions. Everyone, including those with low to moderate incomes would find insurance affordable. Some will exercise their option to self insure.

(6) Congress should free the medical system from unnecessary restrictions that do not in themselves provide any cost savings.

The Medicare Maximum Actual Allowable Charge limits and the Special Charge Limits are primary examples of fee restrictions that do not reduce Medicare expenditures at all. And they severely impair the delivery of extra levels of medical and surgical care such as is found in centers of professional excellence. They limit access to the finest physicians by encouraging excess demand for their higher level of service at an artificially low level of cost.

The Relative Value Study has no potential for cost savings that could not be generated by percentage reductions in the present fee schedules. Such a major change in the health care system has the potential to cause serious disruptions. This is major surgery to the health care system that is not necessary.

The Medicare participating physicians program should be ended. It is costly to administer and discriminates against non participating physicians and their patients. Studies show that a disproportional number of service billings come from participating physicians. This may be a result of lack of patient supervision in the billing process. The more a patient participates in the payment or co-payment of their medical services, the more he or she becomes a watchdog for Medicare system abuses. I have noted that few patients review their charges if their coinsurance insulates them from copayment.

Support for Health Maintenance Organizations (HMO's) and capitation arrangements should be eliminated. These systems impose a disincentive to care upon providers. And they redistribute valuable health care funds to a middleman level of unnecessary corporate administors and venture capitalist investors, at the expense of the patients who would otherwise have received the whole value of those funds. The cost savings generated by these alternative health care systems is small and could just as easily be accomplished by a minimal increase in the percentage reductions to be spread over all providers.

Those members of Congress and staff, who are conducting research into the nature of the health care system are invited to tour the Rand Eye Institute. Such a visit will provide an orientation to quality care, patient expectations, and the true benefits that American ophthalmology has been able to bring to our people.

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